Standing Committee on Veterans Affairs

Annual Report

November 2004

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House of Assembly
Nova Scotia

Hon. Murray Scott
Speaker
House of Assembly
Province House
Halifax, Nova Scotia

Dear Mr. Speaker:

On behalf of the Standing Committee on Veterans Affairs, I am pleased to submit the 2003 / 2004 Report of the committee for the First Session of the Fifty-Ninth General Assembly.

Respectfully submitted,

Gerald E. Sampson

Mr. Gerald Sampson, MLA
(Victoria-The Lakes)
Chairman
Standing Committee on Veterans Affairs

Halifax, Nova Scotia
2004

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Foreword

Although there is no written mandate of the Standing committee on Veterans Affairs, the report was written with the understanding that the committee be established for the purpose of considering matters pertaining to the Royal Canadian Legion and Veterans of the Canadian Armed Forces.

The report is written under individual topics outlining the concerns and issues brought forth from each group / organization.

105-05627/

ORGANIZATIONAL MEETING

October 30, 2003

WITNESSES

There were no witnesses present during this meeting. The Standing Committee on Veterans Affairs had, at this juncture, entertained public requests to meet with the committee. The Committee received a written request from the Royal Canadian Legion - Nova Scotia/Nunavut Command.

In addition, the Standing Committee had also invited representatives from Veterans Affairs Canada and the Insurance Bureau of Canada to meet with them to discuss issues and concerns that were brought forth by the Royal Canadian Legion, such as benefits and services; and commercial insurance rates for Legions and its local branches.

References to, and within, this transcript can be found on the Nova Scotia Government Web Site at: http://www.gov.ns.ca/legislature/hansard//comm/va/va_2003oct30.htm

ROYAL CANADIAN LEGION - NOVA SCOTIA/NUNAVUT COMMAND

November 20, 2003

WITNESSES

Royal Canadian Legion - Nova Scotia/Nunavut Command
Mr. Victor Barnes - Command President
Mr. George Aucoin - First Vice President
Mr. Jack Hatcher - Chairman, Veterans Services & Seniors Committee

INTRODUCTION

Over the past several years the cooperation between the Legion Committee and the Standing Committee on Veterans Affairs has been a benefit to veterans, seniors and Legion members. The Royal Canadian Legion is very pleased with the results of this close relationship. Some examples of cooperation between the two entities are: the renaming of a section of Highway No. 102 (Veterans Memorial Highway); establishing a compulsory Canadian high school history course; the veterans licence plate; the meeting with the fire marshal that has been resolved to the Legions satisfaction and of their branches; the new no smoking regulations and the working relationship that the Legion has had with government officials in this matter regarding its branches; the senior safe driving program is satisfactory and the new Volunteer Protection Act that has put a lot of people at ease as far as helping out in the communities.

MATTERS OF DISCUSSION

Although there were a number of issues discussed throughout the meeting, outlined below are a few of the key issues.

— Self-Service Gas Stations. As previously presented to the Standing Committee on the issue of Self-Service and Full Service Gasoline Stations, the Legion continues to receive a number of inquiries and complaints from seniors, veterans and disabled persons about the lack of full service gasoline stations. It is almost impossible to get to a full service station, unless one drives quite a distance. The Legion would like to try to stop the progress of the self service stations and make sure that in each area there is a full service station. The Legion asked the Standing Committee, again, to assist them with this inquiry in any way possible.

The Standing Committee wrote to the Minister of Service Nova Scotia and Municipal Relations pointing out the absence of full-service stations available to senior citizens, veterans and disabled persons and to request that department officials work with the petroleum industry to try to find ways of addressing this growing problem. The Committee also noted that they have written a letter on behalf of the Legion to the Retail Gasoline Dealers Association of Nova Scotia to encourage the petroleum industry to take this issue seriously, and to take steps to provide a good mix of service as well as to provide opportunities for disabled persons to receive assistance in fueling their cars.

In response to the Committee's correspondence, Service Nova Scotia and Municipal Relations has stated that the government no longer has the authority to force the major suppliers to offer full-service in any particular outlet, that many consumers in the smaller centres and rural areas prefer the convenience of the full-service option , and that the department has been working on a solution to address the same concerns which the committee has heard and will post on its website the location of all the gasoline stations located in the province and the type of service each provides. It was also stated that this option may not be of use to all veterans and seniors since it relies on the Internet and they hope that the Senior Citizen's Secretariat will distribute the same list to their stakeholders.

The Retail Gasoline Dealers Association of Nova Scotia stated that they recognized that many motorists are gradually experiencing a decline in available services at retail outlets and in their opinion this trend is expected to continue. However, the decision to install self-serve facilities are almost exclusively made by the oil companies. Most independent retail dealers do not have the ability or confidence in the industry to invest the required capital and considering the business climate within the industry today it is unlikely these conditions will change as almost all self-serve outlets are oil company operated or controlled. The Retail Gasoline Association always encourages retailers to train their staff to respond to motorists with special needs where an outlet has both full and self-serve offerings and shares the concern that senior citizens and persons in need of special assistance will continue to face greater difficulty accessing lower gasoline prices and other services. The Association does recognize that there is a need for some strictly self-serve outlets based on recent claims of customer preferences.

Further to this, attention was brought to the provincial rest stop in the Westville area and the fact that the establishment has only self-serve gas. Since it is a provincial rest stop it would have received some government funding and as such why does it not have any sort of full-service access in light of the concerns raised by the Legion and disabled groups.

As a result, the Standing Committee on Veterans Affairs unanimously agreed to pass a motion to write to the Minister of Transportation and Public Works requesting,

> "information confirming provincial funding to the Westville Provincial Rest Stop and for the Department to look into providing full access service to veteran, senior and disabled motorists who frequent this establishment".

— Video Lottery Terminals. The Legion has addressed this problem over a number of years, especially with respect to the breakdown on VLT revenues. The Legion was advised that they would receive a letter or have a meeting with the Minister of Finance, and have met several times with the Minister and staff of the Gaming Corporation, but with unsatisfactory results. The Legion has, again, asked the Standing Committee to assist them in addressing this particular issue.

The Legion claims that the government now receives 78.6 per cent of the take on the VLTs and the Legions get 21.4 per cent, but from these revenues they have to pay out such expenses as maintenance on the machines, telephone lines and other related costs, so their actual take is about 10 per cent. Therefore, they want to receive a higher percentage than the current one.

— Hospice. Currently there is no hospice east of Montreal. An initiative of the VON, in conjunction with the local Legion, is a hospice in the Kentville area for which they are trying to raise funds to get it up and running. Once this hospice is in operation the Legion will ask the government to maintain it. This can save the government money since it currently costs less to house people in a hospice than in a hospital. It will be a first for Nova Scotia and the Legion is hoping that it will catch on throughout the rest of the province. As explained, a hospice is a place where a person who is dying can go and die in peace. It is a family-oriented environment where family can go and visit patients in their private rooms 24 hours a day. By contrast, in a hospital patients are restricted with respect to visitors and visiting hours. Also hospices can be used by anybody, not just veterans; whereas, the veterans wing in a hospital is strictly for veterans.

— Veterans Affairs Canada Benefits and Services.

- The Veterans Independent Program (VIP) is now available to the spouse of a veteran for the remainder of the spouse's life when the veteran is deceased. Veterans Affairs Canada made this change to services in 2003, but the program is retroactive to only 1990 for widow entitlements.

- An automated system now in place at the Department of Veterans Affairs. Veterans and their families had concerns about the level of service they received when calling the department; however, according to the Legion, there was a phone number available to service officers who gave out the number to everybody. This, in turn, backed up the phone lines making it impossible for clients to get through, so Veterans Affairs Canada removed the line and initiated a new automated service.

- Veterans Affairs Canada and the Legion have unanimously agreed, during a recent meeting, to set up a regular schedule of meetings to discuss and try to resolve problems within local legion areas and throughout the province.

- Merchant Marine benefits are slow to initiate as the Department of Veterans Affairs has to take the time to evaluate and validate who is/ was actually a Merchant Marine Veteran. The problem is most of the people who served with these veterans or were veterans themselves, are deceased, and Veterans Affairs Canada will not sanction the benefits until they receive verification that the person was a veteran or that some other person receiving the benefits served with that particular veteran.

DOCUMENTATION

The following documentation was requested by the Standing Committee on Veterans Affairs and furnished by the Royal Canadian Legion, Nova Scotia - Nunavut Command and the Department of Transportation and Public Works:

Correspondence from the Royal Canadian Legion regarding the hospice program;

Correspondence from the Department of Transportation and Public Works regarding Provincial Rest Stops in the Pictou and Cumberland County Rest Areas.

References to, and within, this transcript can be found on the Nova Scotia Government Web Site at: http://www.gov.ns.ca/legislature/hansard//comm/va/va_2003feb13.htm

VETERANS AFFAIRS CANADA - ATLANTIC REGION

January 15, 2004

WITNESSES

Veterans Affairs Canada - Atlantic Region
Ms. Krista Locke - Acting Regional Director General
Mr. Barry Gallant - Acting Associate Director General
Mr. Paul Brown - District Director for Nova Scotia
Mr. Gordon Thomas - Client Service Team Manager, Halifax Office

INTRODUCTION

Veterans A ffairs Canada' s (VAC) mission is to provide high quality client-centred services and benefits that respond to the needs of veteran clients and others including Canadian Armed Forces and RCMP as well as their families. This is in recognition of their services to Canada and as well to keep the memory of their achievements and sacrifices alive for all Canadians.

The reporting structure within the department is as follows: there are five regional offices located across the country. In the Atlantic Region, the office is located in Dartmouth, and there are four district directors within Nova Scotia.

Veterans Affairs Canada has initiated their integrated service delivery framework, a comprehensive review of the way they provide services and what services they do provide. VAC is trying to meet these changes by organizing teams in each district into what they call a client service team; that is, a number of professionals on the team, along with support to provide a whole range of services to the client.

In order to allow the team in a district office to concentrate on the more complex and difficult client issues, Veterans Affairs Canada has set up across the country, three centres which they term loosely as the National Contact Centre. These "call centres" will take phone calls from clients. Although there are three centres, there are only two numbers, one for English speaking clients and one for French. This will make things much easier for clients, and clients will be connected to an actual person – not a voice automated system.

Veterans Affairs Canada has also incorporated the same system with their treatment program; ie, health benefits. They have centralized most of the treatment authorizations in three sites, Newfoundland, Montreal and Vancouver. Those three sites will do most of the paperwork related to treatment, and will also be the sites that will answer calls from the providers of service.

At the same time, Veterans Affairs Canada also looked at the corporate finance division and made sure that is as efficient as it can be. In addition to looking at the organization, VAC looked at the legislation and the regulations within the department, and have made some changes to improve service. They have also enhanced the amount of money that the former prisoners of war can receive, and reduced the amount of time that these veterans would have had to be a prisoner of war in order to receive compensation.

The department has re-established the Education Assistance Program, which is a program for children of veterans who either died because of their injuries in service or who have had a disability pension of 48 per cent and over and is deceased. They have also changed the Veterans Independence Program (VIP) which is now available to spouses of veterans. If the veteran is deceased, the spouse can continue to receive the housekeeping and grounds keeping maintenance that the veteran would have been receiving. Increased health care accessibility for medium-disabled pensioners has also been changed so that anybody receiving a disability pension of greater than 48 per cent will now be entitled to treatment benefits for any ailment for which they are receiving a recognized treatment.

In addition to these changes, Veterans Affairs Canada has also filled in a loophole relating to overseas veterans. Currently overseas service veterans now have access to a long-term care facility. The department has reinstated long-term care, nursing home care for Allied veterans who have lived in the country for more than 10 years and former prisoners of war will not only receive their pensions, but are also eligible to receive VIP.

MATTERS OF DISCUSSION

Although there were a number of issues discussed throughout the meeting, outlined below are a few of the key issues.

— Client Groups. On a national client base, Atlantic Canada has roughly 33,000 clients/veterans. In the regional client base, Nova Scotia has close to half of the clients in the Atlantic Provinces at 45.5 per cent; the other three provinces make up 55 per cent. The survivor group across the country will be approximately 23,000 because of the changes in the VIP and the continuing growth of retiring veterans from the RCMP and the Canadian Forces groups.

— Disability Pension Program. This program provides financial compensation for death or disability related to military service. It is not an income replacement program, it is the amount of compensation based on the extent of the disability, and is available to veterans and some qualified civilians. It also provides for survivor benefits that are payable to spouses or dependent children.

— War Veterans Allowance. This is a means-tested income assistance program available to veterans and survivors, and qualified civilians. It offers veterans a gateway to other programs that are offered through Veterans Affairs Canada.

— *Institutional Care. Veterans Affairs Canada has a number of beds located at various facilities* that they contract with the province. Currently VAC has 334 beds that they refer to as priority access beds in 12 facilities throughout the province. Because of age and other maladies, many of their veterans are requiring this type of service. Veterans Affairs Canada use to have what they called active treatment beds; however, since they do not use active treatment beds anymore, VAC has converted those beds into long-term care beds and because of the long wait list, beds are issued on an as needed basis. The department now allows a veteran access to that same type of service in a community bed and the department will pay for it.

— Veterans Independence Program. This is Veterans Affairs Canada's home care program, the goal of which is to help eligible clients remain healthy and independent in their homes and communities. It is needs-based and does not replace other federal, provincial and municipal programs.

Other benefits currently under review that may be associated with the VIP program is extended physio and gym memberships. There is some flexibility within this program and the area counsellor who would make some of the decisions in consultation with the health care team on certain requests of this nature.

— The Last Post Fund. This program administers the funerals, burials and grave markers of veterans. It is means-tested on the estate.

— Canada Remembers. This program is celebrated to keep the memory of the veterans' achievements and sacrifices alive for all Canadians.

— Veterans Week. This is the week that leads up to Remembrance Day. Veterans Affairs Canada has events all through the province that they support and attend. The annual ceremony of the Black Battalion, the Battle of the Atlantic, an Honours and Awards division in Ottawa which is responsible for in issuing medals and decorations to First and Second World War Veterans and some medals from the Korean War, to name a few of the events and ceremonies.

— Merchant Marines. Part of the issue with regard to the percentage of Merchant Marine applications being approved or not approved is that VAC cannot find any documentation on them. The department cannot reduce the requirements, but need some kind of document and/or a witness stating in a declaration that they were on a particular ship with the veteran in question.

— Area Counsellors. Currently there are 14 area counsellors in the Halifax Regional Municipality. Area counsellors are categorized by postal code, and are responsible for meeting with veterans and their families and other representatives to explain the benefits and services that are available.

DOCUMENTATION

The following documentation has been requested by the Standing Committee on Veterans Affairs and furnished by Veterans Affairs Canada.

Veterans Affairs Canada Policy 3.0 - Gym Membership

Further information from Veterans Affairs Canada regarding:

Veterans Independence Program Lifetime Continuation for Spouses;
Last Post Fund and unmarked Veterans' graves;
Canada Remembers Youth-Related Programs;
Merchant Navy Applications;
Veterans Affairs Field Staff.

References to, and within, this transcript can be found on the Nova Scotia Government Web Site at: http://www.gov.ns.ca/legislature/hansard//comm/va/va_2003may01.htm

Royal Canadian Legion - Nova Scotia/Nunavut Command
"Youth Programs"

February 26, 2004

WITNESSES

Royal Canadian Legion - Nova Scotia/Nunavut Command
Mr. Victor Barnes - Command President
Mr. Jack Hatcher - Honorary Treasurer
Mr. Steve Wessell - Chairman of Command

Observer:
Mr. Tom Waters - Assistant Editor, Torch Magazine

INTRODUCTION

The Royal Canadian Legion (RCL) - Nova Scotia/Nunavut Command met with the Standing Committee to ask for guidance and assistance for their youth programs. These programs are the Legion training camp, youth sports, the Call to Remembrance and cadets.

The Legion Leadership Training program

In the summer of 1964 Nova Scotia Command set up its own Leadership Training program for an estimated 60 students. The Command recruited 30 girls and boys who would be 15 to 17 years of age during the year of the camp, completed Grade 10 or 11 and were planning to return to school the following year. The first camp was held at Acadia University, and subsequent ones to be held in other areas when and if accommodations became available. Camps have been held at the Agricultural College in Truro and St Francis Xavier in Antigonish. Currently the total number of students who attend camp is 42.

The purpose of the camp is to offer the student an opportunity to develop leadership skills. This allows the individual to develop public speaking and communications skills, to learn motivational skills, to be able to organize groups to conduct a specific task or pursue a course of action for the benefit of the group. The ultimate goal of the camp is to help the student develop his or her skills so that they will make a potential difference to any team and/or organization in which they may be involved.

The main cost of this camp is covered by Nova Scotia/Nunavut Command, however, the local branches contribute towards the total expenses by paying a student's registration fee and may also assist in the transportation of the student to and from the camp and a bit of spending money. The camp is well conducted by eight professional teachers from various schools throughout the province and two chaperones. The camp is 10 days in duration and the students are covered by group insurance while in attendance.

Students must be recommended by their high school. Final selection is made by the Nova Scotia/Nunavut Command Leadership Training Committee and the camp director. Due to the rising cost of this camp, especially renting university facilities, the Command is having difficulty meeting its commitments although they have been advised that they may be eligible for some funding from the provincial government. The annual cost of renting a theatre for eight days is approximately $5,000. which is a very significant portion of the annual cost of $65,000 for this camp. In addition to this is the cost of uniforms, supplies, accommodations, food, and numerous other equipment required for a camp of this magnitude.

Track and Field Program

The Royal Canadian Legion track and field program dates back to the early 1950's. The present format of the camp was adopted in 1975 and has operated, with improvements for the past 29 years.

The camp is six days in duration, plus two days travel. The cost of this camp ranges in the vicinity of $450,000 with Nova Scotia's share being $40,000-plus. Each year the province can select up to 38 athletes to attend this camp. In addition, they may send two coaches and four chaperones. Approximately 200 athletes from across Nova Scotia participate in the Legion trials in July.

Up until the 1996-97 fiscal year, Sport Nova Scotia helped to fund (approximately $3,000/year) this program; however, the agency decided that the Legion was no longer qualified for assistance, and so the Legion has lost that funding. This program is in dire need of funding and unless it is obtained, this will be the last year the Legion can sponsor that program.

Cadet Program

The cadet program within the Command is small, however, it must be counted in their youth programs. The Legion branches sponsor over half of the 90-plus cadet units. In addition, the Command sponsors the Royal Canadian Legion Medal of Excellence making available a medal to a deserving cadet in each unit across the province.

They also make available to each cadet league $1,000 to offset the costs of programs that advance the well-being of the cadets: for example, air cadets have an effective speaking competition; the Army cadets have a small rifle shooting program and the sea cadets run a bosun whistle leadership program. The above programs cost the Command approximately $5,000 annually.

Call to Remembrance Program

The Call to Remembrance Program is an education quiz program designed for junior high and middle school students in Nova Scotia with a format based on the Reach for the Top quiz show. First presented in Windsor, Nova Scotia late in 1995, five schools participated with students from Grades 8 & 9. The programs is now open to any student enrolled in Grades 7, 8 or 9 or in the case of a middle school, Grade 6.

The start of the quiz program covered subject matter based on Canada's participation in World War I, World War II, Korea and local military history. Topics such as the Gulf War, Afghanistan, NATO and peacekeeping missions have since been added to the program.

Since 1995 the Call to Remembrance Program has grown to include schools from Yarmouth to Sydney. Each school team consists of a maximum of six players, plus a coach. Presently 35 to 40 schools in eight different provincial zones are participating in regional competitions across Nova Scotia. This equates to approximately 200 to 240 students in competition.

Many hours of volunteer labour and money are donated by individual Legion branches in each zone across the province, in order to stage a regional competition. Each zone must have an organizing committee, they must prepare question packs, organize judges, timekeepers, scorekeepers and a moderator. Each regional committee could easily spend 500 to 600 volunteer hours preparing for and running a competition and spend upwards of $1,200 to $1,500.

Multiplying those figures by a low average of eight of 15 zones participating on a yearly basis shows that the local branches expends approximately 4,000 to 4,800 man-hours and $9,600 to $12,000 across the province in regional competitions. The provincial committee expends upwards of 900 to 1,000 man-hours in preparation for each competition. Approximately $8,000 to $9,000 is budgeted annually to cover the cost of equipment and repair, venues, administration, and food and lodging, amongst other things.

Presently, the Call to Remembrance Program is floundering despite the fact that the volunteers are still able and the students are still willing to learn and compete. The funding to continue the program is much harder to obtain at the branch and provincial level, due to growing commitments to veteran and senior communities and the ever-increasing costs of maintaining a Legion branch, including the skyrocketing cost of insurance in Nova Scotia.

The Legion Command is in severe financial difficulty. Due to the rising costs of all of their programs they need assistance as soon as possible. The Command has taken great pride in organizing and funding these four youth programs at a cost of approximately $125,000 per year. However, they find they can no longer support these programs financially at this level and must ask for assistance outside the Legion. The alternative is to cut back on the number of youth they can support or cancel the programs.

MATTERS OF DISCUSSION

Although there were a number of issues discussed throughout the meeting, outlined below are a few of the key issues.

— Program Fees. This year, the RCL faced a $6,500 increase in the university fee for the leadership training program alone, and the other fees are going up as well. They have come to a point that they just cannot afford it anymore. Currently, they may lose local branches because of the increased cost of insurance.

— Military Membership. Legion memberships are basically open to any Canadian citizen who would like to join. The relationship with the local military has grown considerably; the local military have helped the RCL with Dominion conventions, parades and facilities, and venues. The RCL supports, financially and PR-wise, the military through DND Family Days. Approximately $5,000 a year is made available to the program. The RCL also lends financial support to DND's Falls Lake facility.

The RCL has developed a new program with regard to the military, called the Military Member at Large Program, where serving members across Canada can become a "floating" member of the Legion. Military personnel are not necessarily tied down to one Legion Branch where they pay dues, but once they have retired or settled down in a certain area they can join a certain branch.

— Veterans Affairs Canada. According to the Royal Canadian Legion, the only thing that Veterans Affairs Canada assists with on behalf of youth is some study material and supplies for the Call to Remembrance program. Veterans Affairs will not deal with youth programs; they stay strictly with veterans and the veterans programs that are in existence or are being developed.

— Insurance Rates. The Legion Command has had a few insurance companies call them inquiring if they are interested in discussing insurance rates . The Legion has informed the companies that they would be more than willing to do so, however, the problem that concerns the them, at present, is that they have been trying for quite a time to get one insurance company to cover all of the Legions in the four Maritime Provinces.

— Full-Service/Provincial Rest Stops. Nova Scotia does have a provincial rest stop which was built in Westville and subsequently there will be a second rest stop constructed on the Cobequid Pass/Thompson Station. Discussion did ensue at the Committee level that these rest areas were designated as provincial rest stops. The actual agreements from the Department of Transportation and Public Works indicated that for both of the rest stops, Crown land was signed over to the developer along with a grant in the amount of $200,000 for the establishment of these rest stops. The concern of the Committee was that since they are provincial rest stops, why is the province not making it a requirement that if there is going to be fuel service that it should at least have a minimum requirement to provide full-service pumps to deal with the issues raised by seniors, people with disabilities and others who are not comfortable using the self-serve. The criteria set out by the government for anyone who wishes to operate one of the provincial rest stops, indicates no reference to fuel service.

As a result of this matter of discussion, the Standing Committee on Veterans Affairs unanimously passed the following motion:

> "Therefore be it resolved that the Standing Committee on Veterans Affairs call upon the Minister of Transportation and Public Works to seek an amendment to the existing Memorandum of Understanding with the two developers for provincial rest stops and to add in a clause which would require where fuel service is made available at the provincial rest stops that a minimum requirement be established for providing full service fuel service to address the issues raised by the seniors, Legions, veterans and other concerned Nova Scotians".

Also:

> "That it also be resolved that the Department of Transportation and Public Works of the Government of Nova Scotia make it a mandatory requirement that any future provincial rest stops, in their Memorandum of Agreements if fuel service is to be provided, that minimum requirements are established for full-service fuel service".

DOCUMENTATION

The Standing Committee on Veterans Affairs had requested and was furnished with the following documentation from the Department of Transportation and Public Works,

Correspondence regarding the Provincial Rest Stops in both Cumberland and Pictou Counties.

Regarding the multitude of issues the Legion has brought before the committee with regard to their youth programs, the Committee put forth the following motion.

> "Be it resolved that a subcommittee of the Veterans Affairs Committee be struck to address issues brought forward to the committee by the Royal Canadian Legion, Nova Scotia/Nunavut Command".

References to, and within, this transcript can be found on the Nova Scotia Government Web Site at: http://www.gov.ns.ca/legislature/hansard//comm/va/va_2004feb26.htm

Sub-Committee on Veterans Affairs

Thursday, March 25, 2004

In Attendance

Mr. Michel Samson, MLA - Chairman
Mr. Jerry Pye, MLA
Mr. John Chataway, MLA

Meeting details

Royal Canadian Legion - Youth Programs

The sub-committee discussed the various issues that the Royal Canadian Legion had previously brought before the Standing Committee regarding RCL's youth programs and their lack of funding for such programs.

The sub-committee undertook to write, on behalf of the Royal Canadian Legion, to various government and departmental office inquiring about the type of funding and/or assistance that could be attainable by for its youth programs.

Veterans License Plate Program

There were still complaints and issues regarding the issuance of Veterans License Plates by various military and civilian persons. The sub-committee has endeavoured to write to the Royal Canadian Legion regarding these concerns and to ask if there is a possibility that the Royal Canadian Legion's executives and members would review the definition of a "veteran" with respect to the Veterans License Plate program.

Insurance Bureau of Canada

In light of the recent events surrounding rising insurance rate, the sub-committee has decided to issue an invitation to Mr. Don Forgeron of the Insurance Bureau of Canada to meet with them regarding the increase of insurance rates for Royal Canadian Legions.

Insurance Bureau of Canada

May 27, 2004

WITNESSES

Insurance Bureau of Canada
Mr. Don Forgeron - Vice-President, Atlantic Region

ING Insurance Company
Mr. Dennis Furlong - President, Atlantic Region

Lombard Canada
Mr. Stan Keeping - Commercial Lines Director

INTRODUCTION

In spite of the tremendous amount of good work and goodwill that Legions generate in communities across this country, when it comes to liability insurance, unfortunately the Legions find themselves placed in a category with many other similar commercial risks. Two predominant premiums that Legions pay and which have caused concern are the commercial property and commercial liability insurances.

The basic formula when it comes to insurance premiums comes down to the premiums that insurers take in, and the interest income that they earn on those premiums before claims are paid. Subtract from that the claims paid out and expenses to do business, and what is left over at the end is a profit.

Commercial Premiums

Commercial premiums have increased over the years due to rising claims costs, which drive premium growth more than any other single issue. On the commercial side there has been a tremendous increase in the cost of re-insurance, which is the insurance that insurance companies buy to protect themselves from large losses. Then there are capital and capacity issues. Years of low earnings for the industry has meant that capital reserves have been severely depleted. The federal regulator requires that insurance companies have sufficient money on reserve in order to pay claims and when premiums rise it requires more capital to write the same amount of business because the premium volume is higher.

The Insurance Bureau has seen very serious issues develop with capital as a result of capacity – capacity refers to the capacity of the insurance company to write business, and if an insurance company requires an injection of capital in order to continue writing business, or to write more business then because of poor earnings over the last several years, many companies have opted not to write business.

On the commercial side, there have been many cases where companies have simply withdrawn from the marketplace for a variety of reasons, i.e. a lack of desire to put more capital into a line of business that was losing money; the inability of the insurance company to properly price their product limits them in trying to attract shareholders or investments into that company when the return on equity is low or non-existent.

Again, in spite of the work that the Legions do in their communities for veterans and so on, when it comes to liability exposure, because alcohol is being served from these premises, they are classified and pose very much the same types of risks that a bar or a similar type of establishment would pose. Legions do still enjoy lower premiums than a traditional bar would realize, but there is no question that they still are significant.

Royal Canadian Legion

The Insurance Bureau has met with the Royal Canadian Legion on at lease one occasion to discuss what some of the potential solutions might be. One large provincial broker, who is attempting to secure for the Legions a group plan, suggested that if they were able to pool all of their resources, all of the Legions under one group plan, there might be some efficiencies there and there might be some opportunity to lower those premiums.

The industry is trying, through meetings with the Legions, through the development of group plans, through offering advice on risk management, to make available to Legions the expertise that insurance companies now have on how to minimize risk. There are things that all stakeholders can do to try to improve the situation.

During the course of the 1990's when premiums were flat, risk management on behalf of consumers and commercial establishments really was not at the forefront because there was no pressure to make sure that these establishments were practicing proper risk management techniques; however, now that those rates have risen; there is a need on behalf of the people purchasing the coverage to make sure that they employ the best risk management techniques possible. That alone will not solve this problem, but it will certainly help to mitigate some aspects of it.

Government

Governments also can play a role in this issue. There are legal issues that arise related to Legions and when talking about what the risk that is posed by Legions and other similar establishments, it centres on alcohol liability. For example, if a Legion is found to be even 1 per cent liable for an accident they could, depending on the circumstance, be forced to pay 100 per cent of the claim, because of the way legal liability laws are constituted in Canada.

MATTERS OF DISCUSSION

Although there were a number of issues discussed throughout the meeting, outlined below are a few of the key issues.

— Some of the reasons for high increases in commercial rates are due to rising claim costs; re-insurance; capital/capacity; and risk management increases.

— Alcohol liability means that the Legions take on the same risks that a similar establishment or bar would, although the Legions do enjoy a lower premium than others.

— One solution would be a group plan for all Legions. This would provide an opportunity for lower insurance rates. Some insurance brokers/agents and Legions across the country are in negotiations regarding the group plan; however, it is still undecided about who will pay the costs. Will it be paid by Dominion Command, the provincial Commands or local Legions.

— Of the 119 Legions currently in the province, five or six will have to close by years end due to the increase in insurance rates. The RCL is trying to amalgamate some Legions with others; however how other Legions would receive this is yet to be determined. The RCL also stated that they will be happy to meet with IBC representatives to discuss further negotiations with regard to the proposed group insurance.

DOCUMENTATION

There was no request for further documentation from the Insurance Bureau of Canada.

References to, and within, this transcript can be found on the Nova Scotia Government Web Site at: http://www.gov.ns.ca/legislature/hansard//comm/va/va_2004may27.htm

STATEMENT OF SUBMISSION

All of which is respectfully submitted to the House of Assembly
This 20th day of January, 2005

Mr. Gerald Sampson, MLA (Chairman)
(Victoria-The Lakes)

Mr. Cecil O'Donnell, MLA
(Shelburne)

Mr. Gordie Gosse, MLA
(Cape Breton Nova)

Mr. Bill Langille, MLA
(Colchester North)

Mr. David A. Wilson, MLA
(Sackville-Cobequid)

Mr. Bill Dooks, MLA
(Eastern Shore)

Mr. Harold Theriault, MLA
(Digby-Annapolis)

Mr. Jerry Pye, MLA
(Dartmouth North)

Mr. Stephen McNeil, MLA
(Annapolis)

Committee Membership

During the 1st Session of the 59th General Assembly of the House of Assembly, the make-up of the Standing Committee on Veterans Affairs was comprised of the following members:

Mr. Michel Samson, MLA (Chairman)
(Richmond)

Mr. John Chataway, MLA
(Chester-St. Margarets)

Mr. Cecil O'Donnell, MLA
(Shelburne)

Mr. Bill Langille, MLA
(Colchester North)

Mr. Jerry Pye, MLA
(Dartmouth North)

Mr. Gordie Gosse, MLA
(Cape Breton Nova)

Mr. David A. Wilson, MLA
(Sackville-Cobequid)

Mr. Harold Theriault, MLA
(Digby-Annapolis)

Mr. Stephen McNeil, MLA
(Annapolis)

On December 31, 2004, the Standing Committee on Veterans Affairs sadly acknowledges the passing of one of its members. Mr. John Chataway, MLA (Chester-St.Margarets) has passed away due to ill health. Mr. Chataway will be truly missed.

Effective January 1, 2005 Mr. Gerald Sampson, MLA (Cape Breton the Lakes) will be replacing Mr. Michel Samson, MLA (Richmond) as a member of the committee. As well, Mr. Bill Dooks, MLA (Eastern Shore) will be replacing Mr. John Chataway, MLA (Chester-St. Margaret's).

Committee Meetings

The Standing Committee has been meeting on Thursdays since its establishment, and all meetings are open to the public. During the 1st Session of the 59th General Assembly the Standing Committee on Veterans Affairs has met on the following dates.

October 30, 2003
November 20, 2003
January 15, 2004
February 26, 2004
March 25, 2004
May 27, 2004

Transcripts

Transcripts of the committee meetings are available from the Legislative committees Office, 3rd Floor, Dennis Building, 1740 Granville street, P.O. Box 2630 Station M, Halifax, NS B3J 3N5 or from the Legislature web-site:
http://www.gov.ns.ca/legislature/COMMITTEES/veteran_affairs.html

Reports

All reports of the Standing Committee on Veterans Affairs are compiled by the Legislative Committees Office and forwarded to the committee members for consideration. Once the report is finalized it is then distributed to the following:

> The Speaker/Clerk of the House of Assembly; all members of the Legislative Assembly; all Presenters who made presentations before the committee; all Legislative Libraries across Canada, including the Territories and media. The report is also available to all persons interested in obtaining a copy from the Legislative Committees Office and is also available on-line through the provincial government web-site.

Acknowledgements

The Standing Committee on Veterans Affairs wishes to extend its gratitude to the following:

> The Royal Canadian Legion, Nova Scotia/Nunavut Command; Veterans Affairs Canada and the Insurance Bureau of Canada. For their time and cooperation, special thanks is extended to Mr. Robert Kinsman, Manager of Hansard; Hansard Staff; to Mr. Jim McInnis, Co-ordinator of Legislative Television; Legislative Television Staff; Mr. Michael Laffin, Co-ordinator, House of Assembly Operations; House of Assembly Staff; and to Ms. Margaret Murphy, Legislative Librarian and Librarian Staff. The Committee also wishes to thank Ms. Darlene Henry, Committees Office, for her hard work and guidance throughout the year and for the preparation of this annual report.

Appendices

A) Royal Canadian Legion, Nova Scotia/Nunavut Command
— Correspondence regarding the hospice program

Department of Transportation and Public Works
— Correspondence regarding Provincial Rest Stop in Pictou County

B) Veterans Affairs Canada
— Gym Membership Policy
— Veterans Independence Program Lifetime Continuation for Spouses
— Last Post Fund and unmarked Veterans' graves
— Canada Remembers Youth-Related programs
— Merchant Navy Applications
— Veterans Affairs Field Staff

C) Royal Canadian Legion, Nova Scotia/Nunavut Command
— Additional correspondence regarding Provincial Rest Stops in both Cumberland and Pictou Counties

APPENDIX A

VON KINGS HOSPICE FOUNDATION

ANNUAL REPORT

2002-2003

Port Williams, 1lt June 2003

VON KINGS HOSPICE FOUNDATION

REPORT FOR THE YEAR 2002-2003

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VON KINGS HOSPICE FOUNDATION

Members of the Board - 2002 - 2003

Dr James R. C. Perkin *Retired Academic Administrator*	Chairman of the Board
Dr Catherine McNally *Family Physician*	
Dr Jeanette Auger *Hospice Consultant and* *Professor of Sociology*	Fundraising Committee
Dr Joelle Caplan *Clinical Psychologist* *Kentville Mental Health Centre*	Nominating Committee
Dr Alex Colville *Artist*	Investment Committee
Canon S.J.P. Davies *Retired Clergyman*	Publicity Committee
Dr Deborah Day *Counsellor and Consultant*	Vice Chair of the Board Nominating Committee
Mr Robbins Elliott *Retired Federal Public Servant*	Treasurer of the Foundation Nominating Committee
Mr Douglas A. Seamone *Consulting Engineer*	Property Committee
Dr S. Maurice Tugwell *Professor of Economics*	Investment Committee
Mr Chopin Viger *Retired Businessman*	Fundraising Committee

* * * * *

Resource Person
Ms Brenda Allen
Manager of Volunteer Services and Program Development, VON Annapolis Valley Branch

Recording Secretary
Ms Krista Laing

REPORT FROM THE CHAIR

The first formal meeting of the VON Kings Hospice Foundation was held in New Minas in August 2000. An annual General Meeting was held in Wolfville in June 2001 and conformed to the pattern required of such meetings of bodies incorporated under the Societies Act. The third AGM was held in Berwick in June 2002: reports were given and a general discussion of Hospice-related issues took place with the members of the public who were in attendance.

In the fiscal year 2002-2003 the Foundation Board both achieved some important objectives and encountered considerable difficulties in moving the Hospice proposal forward. The biggest single difficulty was the failure of the provincial government to guarantee operating funding for the project. The foundation has expressed a confident willingness to raise the $1.6 million to build, equip and furnish a ten-bed facility with a capability of serving an additional ten day-patients each week-day. In September 2002 the District Health Authority (DHA) voted unanimously to endorse the initiative, it being understood that by so doing no financial responsibility was incurred.

On 12 February 2003 a joint letter over the signatures of the chairs of the DHA and the Foundation was sent to the Minister of Health. The letter asked for a meeting to explore the possibility that the government would provide most of the operating costs in the initial years of the Hospice's service. The requested meeting was held on 3 June. Although the atmosphere was cordial and the meeting lasted some 90 minutes, it became clear that government would not provide financial support for a hospice unless a provincial task force, formed to examine palliative care throughout the province, and whose report is expected in the fall, recommends the establishment of such a facility in this area. While we should continue to pursue the possibility of public funding, it is probably time for the Foundation to explore other options.

The Foundation engaged the fund raising firm of Ketchum Canada Inc to assess the potential in this part of the Valley for raising either the $1.6 million for capital purposes, or a much larger sum (in excess of $3.5 million) to build the Hospice and run it for a number of years. The Ketchum report recommended that before any major fundraising campaign is launched, a comprehensive educational and publicity program is necessary. Members of the Foundation have spoken about the Hospice project in a number of contexts; there has invariably been keen interest and some promises of financial support at varying levels. However, the Board accepts the Ketchum recommendation and is preparing to implement it.

The DHA has agreed to lease to the Foundation a parcel of land on the grounds of the Valley Regional Hospital adequate for the construction and operation of a hospice. A site survey has taken place and preparations are in hand to execute a formal lease agreement.

During the year two important policy statements were approved. The first guarantees that 90% of any donation will be applied to the construction or operation of the hospice: 7% will be spent on administrative and fundraising activities; and 3% will be placed in a reserve capital account, intended to create a fund to generate income for the ongoing work of the hospice. A second policy statement deals with the administrative structure of the hospice and was arrived at through careful discussion with the VON Board of Directors.

Early in 2003 the Foundation decided to establish and review on a monthly basis a Priority List of actions necessary to the opening of a hospice. This list will ensure that the Foundation does not lose sight of its main objectives and that work continues in an orderly manner.

The Board was sorry to lose the services of Dr David Acton, who had been a Director from the beginning of the life of the Foundation, and Kenneth Clark, who had been very active in matters related to the work of the Property Committee. We welcomed Dr Catherine McNally, a family physician with considerable experience in the provision of palliative care, and Dr Maurice Tugwell, a Professor of Economics at Acadia University. They have already made significant contributions to the Board.

I close this report with an expression of appreciation of the work of Board members. The work load has been heavy and at this point there is little tangible evidence to show for all the efforts that have been made. I continue to hope that the long-awaited breakthrough will take place in 2003 and that the dream of a functioning hospice will become a reality.

J.R.C. Perkin

REPORT FROM THE VON

The year 2002-2003 has seen a great deal of activity in palliative care on a provincial level. Cancer Care Nova Scotia and the Nova Scotia Palliative Care Association have jointly produced a manual for the training of palliative care volunteers. Cancer Care Nova Scotia has also begun to coordinate education programs for care providers. This year the Department of Health established a Palliative Care Committee that has a range of working groups with representatives from across the province. This Committee is looking at creating equity in the delivery of palliative care services throughout the province by assessing what is in place, what works well and how the best practice models can be shared most effectively. In addition, the DHA in District 3 has established a palliative care committee to look at the delivery of palliative care services in this area. I have attempted to have representatives of VON Annapolis Valley involved in as many of these initiatives as possible to ensure that the concept of hospice is shared and that the model that the Hospice Foundation is developing is always based on best practice.

I have been involved in a number of meetings and consultations with Continuing Care and the DHA where I was able to represent the progress of the Hospice Foundation. I also joined Dr Perkin and Dr Deborah Day in a meeting with the Minister of Health. I have had the privilege of sharing the hospice message with a range of organizations and service groups across District 3 as I presented information on the services offered through VON. In April I was invited by CBC to be a guest on their Radio Noon call in show to field questions on hospice and palliative care.

At the request of Foundation committees I have conducted research and drawn up proposals in an effort to negotiate some of the possible roadblocks to establishing the hospice. I also helped to arrange for a joint meeting of representatives of the Hospice Foundation and the Board of VON Annapolis Valley in an effort to establish a possible Management structure for the hospice.

In the winter a working space was arranged in the VON office for the Hospice Foundation. Approval was also secured for a series of interviews to be booked in the VON office to support the work of the Ketchum consultants. A joint submission was made to HRDC for a summer student to support the fundraising efforts of VON Annapolis Valley and the Hospice Foundation. The proposal was accepted and a student will be shared by the two organizations over the summer.

I have appreciated the ongoing commitment of Hospice Foundation Board members, the VON Board and the community at large to this important initiative. I am hopeful that the work accomplished this year will result in significant steps forward in 2003-2004.

Brenda Allen

REPORT OF THE TREASURER

During the 2002-2003 fiscal year the Foundation maintained a policy of not actively soliciting funds in support of establishing a stand-alone hospice in Kings County. This policy is based, in part, on the recommendation of consultants that the Foundation first undertake a vigorous information program before launching a fund-raising campaign. More significantly, the policy has been linked to the prolonged wait upon a decision by the Nova Scotia Department of Health concerning operational support for the proposed hospice.

The principal expenditure during the year has been on a feasibility study conducted by Ketchum Canada in two phases, costing $22,554.21 in total.

The Foundation now operates three separate bank accounts: Administrative, Investment and Capital Reserve.

The Prime-linked cashable GIC, deposited with the Royal Bank of Canada, currently totals $276,418.53, maturing on 18 December 2003.

Robbins Elliott

'REPORT OF THE PUBLICITY COMMITTEE

At the time of writing we were still awaiting some definite word from the Provincial Government concerning funding for the operating costs of the hospice; the Foundation Board has therefore not mounted a major publicity campaign.

Nevertheless, several members of the Board have made known to a number of community organizations the plans for the hospice.

Our Chairman, Dr James Perkin, addressed Presidents of Canadian Legion branches in Windsor, and the Vice Chair, Dr Deborah Day, addressed a similar meeting in Annapolis Royal. Brenda Allen was heard on the CBC radio program *Maritime Noon*, where she responded to listeners' questions about palliative care and the hospice movement.

Efforts have been made to enlist the services of reporters from the Kentville Advertiser, and they have been most co-operative. An extended interview by Wendy Elliott with Sid Davies made very clear the need for a hospice in our area and the reasons why such a facility would be an asset in the field of health care. There was also an excellent editorial in the Advertiser with an appeal to the Provincial Government to support such a worthy cause.

In the past several months Sid Davies has brought the plans for the hospice to the attention of the following groups:

The Clermont District of the Anglican Women's Association, representing about twenty congregations

The Mount Zion Preceptory No 73, Knights Templar, who subsequently made a five-year pledge to the Foundation

The Central Kings Community Health Board

The Wolfville Rotary Club

The Anglican Clergy of the Clermont Region, representing twenty-five congregations

The Canning and District Council of Churches, representing about eighteen pastoral charges

When the situation re the future of the hospice is clarified, it is the intention of the Foundation to enlarge the membership of the Publicity Committee and to make every effort by the use of all the local media to inform the public of our future plans.

S.J.P. Davies

REPORT OF THE FUND RAISING COMMITTEE

During the fiscal year 2002-2003 the activities of the committee focused on three main issues: fund raising, office support and potential alternative actions that might be initiated.

1. The committee developed a "Request for Proposal" to seek advice and possible directions for its fund raising strategy. One of the most important considerations related to the question of whether the $3.5 million required to build and operate a hospice for two years was a realistic objective. Two companies submitted proposals - Ketchum Canada Inc, and RBR Ltd of Halifax, N.S. After comprehensive presentations by both companies, Ketchum Canada was selected by the Board to conduct a survey at the cost of $20,000 plus expenses. Subsequently, a reduction of the fee by $1,500 was negotiated.

   The final report recommended several courses of action but questioned the advisability of moving forward without serious governmental support. The complete report was distributed to the Board for its consideration, as was a summary and some suggested approaches the Board might consider.

2. The requirement for supporting the Ketchum effort by organizing the many necessary interviews and the need for centralizing related fund raising efforts led to the hiring of Ms Dale Sanford. Her function is to operate an office located in space provided by the VON. A range of initiatives has been started, primarily in the establishment of a data base to facilitate fund raising activities.

3. A sub committee of the Board was formed with the intent of examining alternative courses of action the Board might consider if government funding is not forthcoming. Brenda Allen provided a memorandum identifying various possibilities; the Consultation Committee was asked to identify and cost a range of day services that might be offered by the hospice. The sub committee is considering providing reduced services, the matter of construction, and publicity and fund raising. It is expected that the sub committee will present its recommendations to the Board at the regular meeting in July.

C.L. Viger

REPORT OF THE NOMINATING COMMITTEE

Proposed Board of Directors 2003-2004

Officers		*Retiring*
Chairperson	James R.C. Perkin	2004
Vice-Chairperson	Deborah Day	2004
Treasurer	Robbins Elliott	2004
Secretary	Joelle Caplan	2004

Directors	*Retiring*
Alex Colville	2004
Jeanette Auger	2004
Chopin Viger	2004
Sidney Davies	2004
Douglas Seamone	2005
Catherine McNally	2005
S. Maurice Tugwell	2005

Joelle Caplan
Deborah Day
Robbins Elliott

VON

We have a dream

You can help to make it a reality...

VON CANADA

VON

Hospice Care

For a number of years a group of volunteers and health care professionals in Kings County, Nova Scotia, have been planning for the development of the first free-standing hospice in Atlantic Canada. A hospice is a facility that provides a home-like environment for persons with life threatening illnesses and their loved ones. Hospice is a cost effective and life-enhancing alternative to dying in a hospital.

You can help make this dream a reality by:

1. Giving a donation to the VON Kings Hospice Foundation.
2. Volunteering to serve on a committee of the VON Kings Hospice Foundation.
3. Donating goods or services to build or equip the Hospice.

"...Watching my mother die unsupported without hospice care, with no support for myself or her young granddaughters in her last days shouldn't happen"

Nancy – N.S.

The focus of care in a hospice is to provide quality living until the time of death and to support loved ones as they learn to deal with the loss. This care and support is provided by qualified professionals and volunteers. In addition to serving ten residents, the hospice will provide a day program to accommodate another ten persons per day.

Under the direction of an interdisciplinary team, we will provide skilled palliative nursing service, volunteers to provide companionship, spiritual care and a variety of professional medical and complementary supports, ranging from pharmaceutical advice to massage.

4. Giving assets to the VON Kings Hospice Foundation. These might include cash, GICs, stocks, art, real estate and mutual funds.
5. Naming VON Kings Hospice Foundation as owner and beneficiary of an existing insurance policy.
6. Encourage family and friends to leave gifts to VON Kings Hospice Foundation.
7. Remembering loved ones with memorial gifts.

WHAT DOES VON CONTRIBUTE TO THE HOSPICE?

- Experience • Quality of Service
- Dependability • Reliability
- Trustworthiness • Responsiveness
- Network of Staff • Volunteers

National Coverage with Community Focus

• Integrated Approach in Service Delivery

For More information Contact ON Annapolis Valley Branch Office:

VON Annapolis Valley Branch

15 Chipman Drive
RR#1 Kentville, NS B4N 3V7
Phone: (902) 678-3415
1-800-411-9646

Proudly Canadian not for profit health care agency
Registered Charity # 129482493RR0001

VON KINGS HOSPICE FOUNDATION

What difference will your gift make?

Building

Your gift will support the building, furnishing and landscaping of the VON Kings Hospice.

Palliative Care

Your gift will enable the provision of comfort and support by trained care providers.

Resource Centre

Your gift will provide community access to resources on a variety of topics to help support persons with life threatening illnesses and their care providers.

Day Hospice / Respite

Your gift will contribute to the provision of daily care in the hospice to persons who are being supported to die at home.

I want to contribute in the following way...

☐ I have enclosed a donation to the VON Kings Hospice Foundation.

☐ I would like to have a VON Kings Hospice Foundation representative contact me to discuss these matters in more detail.

☐ I would like to serve on a committee of the VON Kings Hospice Foundation.

Name _____

Address _____

City _____ Province _____

Postal Code _____

Phone ( ) _____

All inquiries will be kept strictly confidential. Charitable tax receipts will be issued for all donations over $10.

Please make contributions payable to:

"VON Kings Hospice Foundation"

Please detach and mail to:
Fundraising Committee
VON Kings Hospice Foundation
15 Chipman Drive
RR#1 Kentville, NS B4N 3V7

COMPLETING THE CONTINUUM

REPORT OF THE MINISTER'S WORKING GROUP

into the proposal to establish a

H O S P I C E

in Kings County

November 2001

REPORT OF THE MINISTER'S WORKING GROUP

on the

VON KINGS HOSPICE PROPOSAL

Letter of Transmittal

November 2001

The Honourable Jamie Muir
Minister of Health

Dear Minister:

On 18 December 2000 you and some of your colleagues met in Kentville with a group representing the VON Kings Hospice Foundation who presented a proposal to establish a ten-bed, free-standing Hospice in Kings County. You agreed to the establishment of a Working Group with a mandate to prepare a definitive business plan for the project. Since that time a representative group has been working diligently and the plan is now complete. I am pleased to forward to you our report *Completing the Continuum*.

Every effort has been made to discover and include relevant financial data, although there remain some issues which can only be determined in the light of experience. We have attempted to present the financial material in the format used by the Valley Regional Hospital in its submissions to the Department of Health.

The two major aspects of the plan are (i) the construction, equipping and furnishing of a building designed to offer all the services appropriate to a Hospice; and (ii) the operation of the facility in a professional and sustainable manner. The best estimates that we can obtain for the first aspect indicate a capital cost of $1.6 million. The best estimates we can obtain for operating costs indicate that the first year those costs will be $1,165,413 (this includes $101,400 in *per diem* rates in connection with the Day Hospice Program).

The VON Kings Hospice Foundation is confident that it can raise from voluntary contributions the capital costs required to build, equip and furnish the Hospice; it can also raise approximately 5% of the operating costs annually, and is seeking government support for the balance. In the first year the government contribution would be approximately $1,010,812, rising to $1,294,132 in Year Two and $1,357,873 in Year Three. At this point the Hospice will have a full complement of patients and costs will stabilize.

There is strong local support for the Hospice project; the clearest evidence of this is seen in the fact that more than $250,000 has been donated towards the capital costs and that further significant gifts totalling almost another $250,000 have been promised on condition that the project proceed without undue delay.

Once you and your staff have been able to study the plan, we would appreciate an opportunity to meet with you to make a formal presentation. In the meantime we will attempt to provide any necessary elaboration or clarification as promptly as possible.

Yours sincerely,

J.R.C. Perkin
Co-Chair

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REPORT OF THE MINISTER'S WORKING GROUP

COMPLETING THE CONTINUUM

EXECUTIVE SUMMARY

Since the early 1990s professional and volunteer care givers in Kings County have noted that the continuum of care in the area is incomplete due to the absence of a free-standing hospice in which palliative care may be offered to terminally-ill patients and support made available to their families and friends. While some patients prefer to die at home and their families can offer the necessary support, for others the home setting is not ideal and an acute care facility is not necessarily the most appropriate environment.

The VON (Annapolis Valley Branch) and the Department of Sociology at Acadia University provided the initial impetus to explore the possibility of establishing a hospice. Focus groups were held, a needs assessment was undertaken, and a feasibility study was conducted. In addition, extensive literature surveys took place and many small (ten beds or less) hospices in Canada and the United Kingdom were visited.

The research indicated strong support from the medical, nursing and general communities for the establishment of a ten-bed, free-standing hospice, which would be the first facility of its kind in Atlantic Canada. In 1999 a VON Kings Hospice Foundation was set up; the first Board of Directors was elected in August 2000. It has become clear that a hospice can be designed, built, equipped and furnished through voluntary contributions from the community. Suitable land is available on the site of Valley Regional Hospital in Kentville. The facility would be of approximately 10,000 square feet and provide all the services appropriate to a hospice. In addition to the ten in-patients there would be the capability of serving ten day-patients and providing respite care. The total capital cost is estimated to be approximately $1.6 million.

A funding strategy has been approved by the Foundation, but to date no formal campaign has been launched. Despite this, over $250,000 has been donated and other significant gifts, totalling almost another $250,000, have been promised, on condition that the project proceed without undue delay.

In December 2000 members of the Foundation Board met with the Minister of Health to seek government support for the establishment of a hospice. Following that meeting a Working Group was set up "to prepare a definitive business plan relative to the construction and operation of a ten-bed hospice." The plan has now been

completed. There is a brief history of the project, and a detailed financial plan, arranged in the format used by Valley Regional Hospital in making submissions to the Department of Health.

The plan concludes that the operating costs of the hospice for the first year, when not all the ten beds would be occupied, would be $1,165,413. The Hospice Foundation believes that, in addition to meeting all the construction and equipment costs, five percent of operating costs can be raised locally. Because the *per diem* rate for service in the day hospice would realize $101,400, the government contribution in the first year would be $1,010,813. The report recommends that government provide 95% of operating costs. The report also stresses that no steps can be taken towards the building of the facility unless government support for its operation is assured.

The average *per diem* cost for a patient in the facilities operated by the Annapolis Valley District Health Authority is approximately $1,133; the estimated costs in the Hospice in year three, when it is operating at full capacity, would be $392.

The recommendation in the report is

> *that the Government of Nova Scotia agree to provide 95 percent of the operating costs of the VON Kings Hospice to be built and equipped by voluntary contributions.*

HISTORICAL BACKGROUND

In the mid-1990s VON staff became concerned that family care-givers often needed more support than Home Care Nova Scotia could provide, especially for those diagnosed as having terminal illnesses. Many persons who choose to die at home in Kings County have limited support systems and possess inadequate resources to purchase additional services. This concern led in 1996 to informal conversations about the need for a Hospice in Kings County, resulting in an initiative to explore that perceived need on a more formal basis. Dr Jeanette A. Auger of Acadia University, her graduate student Alison Bursey, and the Kings County VON, represented by Brenda Allen, Manager of Volunteer Services and Program Development, held a series of focus groups involving interested individuals and professionally qualified people. In the early part of 1997 Dr Auger visited twenty-five small (ten beds or less) Hospices in the United Kingdom and undertook an extensive literature review.

In October 1997 the report *Mind, Body and Soul: Exploring the Need for a Hospice in Kings County* was released, funded largely by VON Canada and the Western Kings Memorial Health Association. [The report is Attachment 1 to this Business Plan.] The report makes one specific and eleven general recommendations.

The specific recommendation was as follows:

> *(that) the VON Kings Branch proceed immediately to conduct a feasibility study into the creation of a free-standing Hospice*

Parameters for the study were suggested.

In 1998 the *Hospice Feasibility Study*, undertaken in response to the specific recommendation above, was released. It had been commissioned by VON Kings Branch, funded by the Eastern Kings Memorial Health Foundation, and undertaken by Cortland Consulting. The report recommended that a purpose-built, free-standing Hospice, capable of accommodating seven persons, be established to offer a comprehensive range of integrated services to terminally-ill patients and their families. It was noted that certain census sub-districts of Kings County have a significantly higher percentage of persons over the age of 65 than the Canadian or provincial average. However, of the 343 patients who received palliative care in the year 2000 (see page 10), 49 had not yet attained the age of 65 years. The consultants found strong support throughout the community for the Hospice proposal. [The report is Attachment 2 to this Business Plan.] In developing the Hospice proposal no consideration has been given to the special needs of terminally ill children. We believe that the palliative care needs of children are highly specialized and best dealt with in the context of the services rendered by the IWK Health Centre.

Since the publication of the Feasibility Study many discussions about the Hospice project have taken place. A deliberative and administrative structure has evolved, although it is still developing in the light of emergent needs. The Board of VON Annapolis Valley (the formal title has recently been changed), remains the parent body of the project, but the continuing activities are carried on through two other bodies. A **Consultation Committee**, having ten members and including three health care providers, has assumed the responsibilities assigned to the Advisory Committee in the Feasibility Study (p.55) and a 13-member **Foundation Board** was formally constituted in August 2000. In general terms, the Consultation Committee is primarily responsible for determining what services the Hospice will offer, and the Foundation Board will be responsible for selecting a site and building a Hospice to offer the identified services and also for raising the money to build and equip the facility. The two bodies are working collaboratively; in due course their roles may change. It was decided by the Foundation, in July 2001, to establish a **Construction Committee** *to oversee the servicing, design, tendering, construction, site work, equipping, and furnishing of a ten-bed Hospice, with the capability of serving 10 additional day-patients*. It is assumed that once the Hospice is operational a Management Board may be the appropriate mechanism through which to carry out the governance, although the protocols, best practice standards and quality assurance norms would be those currently used by the VON.

During 2000 it was decided to plan a ten- rather than a seven-bed facility and also to ensure the possibility of serving ten day-patients at a time. Professional literature suggests that ten in-patient beds is an optimal size for a small Hospice, in terms of both construction and operational costs. Having ten day-patients means that, in any one week, as many as fifty individuals might be served. Because of the intention to move slowly towards full operational capacity, in the initial stage of operation there would be six or seven in-patients and about the same number of day-patients, the numbers gradually being increased to full capacity.

At this time, a preliminary sketch of a possible building was prepared for the Consultation Committee by David Cochrane, of D.B.C. Construction Management Consultants Incorporated, in consultation with Michael Byrne of Byrne Architects. The drawings, which were provided as a voluntary contribution to the project, were of considerable value in clarifying such matters as the size and nature of Hospice rooms and arriving at an overall estimate of building costs.

The Foundation Board established a Property Committee that visited various possible sites and considered different parcels of land that might be purchased or donated. From these considerations it was decided that the ideal site would be a

section of unused land that forms part of the Valley Regional Hospital (VRH) property. At this time it was decided that the Miller Building, situated on the Valley Regional Hospital site, would be closed in 2002. This would necessitate, among other things, the relocation of the services currently rendered by Fidelis House in offering accommodation at modest cost to relatives of VRH patients living at a distance from Kentville, and also providing facilities for an overnight stay for patients whose physicians wish them to be available for consultation on the day following a surgical procedure. The Board of Fidelis House is hoping to build a replacement facility on the same parcel of land as was identified by the Foundation Property Committee. Inspections have confirmed that the site under consideration would be adequate for the construction of the proposed Hospice and a replacement for the present Fidelis House. The Foundation Board and the Board of Fidelis House have agreed to act "independently but co-operatively," so as to maximize the benefits of co-operative action while fully recognizing the very different natures of the two facilities envisaged.

On 28 November 2000 the Chair of the Hospice Foundation Board wrote to the Minister of Health, the Honourable Jamie Muir, acquainting him with developments to that point and seeking a meeting in order to make a presentation outlining the need for government involvement in financing the establishment of a Hospice. On 18 December 2000 the Minister and members of his staff met with members of the

Foundation Board and the Chair and CEO of the Annapolis Valley District Health Authority (AVDHA); Dr Mark Parent, MLA for Kings North was also present. One outcome of the meeting was that the Minister agreed to establish a Working Group "with a mandate to prepare a definitive business plan related to the construction and operation of a ten-bed Hospice." The Working Group would be jointly convened by Dr James Perkin, Chair of the Foundation Board, and Ms Marguerite Rowe, Chief Executive Officer of the AVDHA, who would also act as the Minister's representative. Ms Rowe concluded her service with the AVDHA on 15 August 2001, having accepted an offer of the position of CEO of the Capital Health District in Edmonton, Alberta.

After appropriate discussion with interested parties the composition of the Working Group emerged as follows:

Co-Chairs	Dr James Perkin Marguerite Rowe
from the DHA	Barbara Kaiser Steven Menzies
from the Hospice Foundation	Dr Deborah Day Chops Viger
from the VON Board	John Pierce
from the Consultation Committee	Diane Tedford-Litle

from Valley Regional Hospital	Gail Gordon
from the Medical Community	Dr Robin Bustin, M.D.

In addition, two resource persons were named to the Group: Dr. Jeanette A. Auger, a Hospice Consultant, Chair of the VON Hospice Consultation Committee and a member of the VON Hospice Foundation Board; and Brenda Allen, Coordinator of the Promoting Elder Participation project at the VON and a member of both the Consultation Committee and the Foundation Board.

A site plan showing the possible locations of the Hospice and the new Fidelis House has been developed by a member of the Foundation Board, Douglas Seamone, M.Sc., N.S.L.S, P.Eng., of Hiltz and Seamone Co. Ltd., Consulting Engineers, Kentville [see Attachment 3]. The Hospice building would have a footprint of approximately 10,000 square feet, be largely, although not exclusively on one floor and would be adequate to house all the planned services and activities. The estimated construction and equipment costs amount to $1.6 million. As will be seen in the detailed Budget, the estimated annual operating cost in the first year is $1,165,413. At an early stage of its discussion, the Hospice Foundation Board discussed the Macmillan Green Plan, which has served as a model for the design of a number of small Hospices in the U.K. [see Attachment 4]. On 14 September 2001 the AVDHA

passed a motion approving the formal lease of land for use by Fidelis House and the Hospice subject to certain conditions. A copy of the letter from the Chair of the AVDHA is Attachment 5.

The Foundation Board believes that, on the assumption that land on the Valley Regional Hospital site will be available at nominal cost, the total cost of construction, equipment and furnishings can be met by contributions from the community. Although no formal appeal has been launched, a sum exceeding $250,000 has been received and invested. A further donation of $200,000 has been promised, conditional upon work proceeding without undue delay and other donors have offered to fund the construction or the furnishing of patient rooms. In total, nearly a half million dollars has been raised or committed to this project. There is confidence that the balance of the $1.6 million estimated construction costs can be raised.

The major remaining issue is that of operating costs. Careful estimates, arrived at wherever possible in discussion with suitably qualified financial experts, indicate that the requirement in the first year will be in the neighbourhood of $1.2 million. The Foundation believes that, in addition to the $1.6 million for construction, equipment and furnishings it would be able to raise approximately $60,000 per year, or 5% of the operating cost. This would mean that the Government commitment for the first three

years of the Hospice would be: $1,010,812, $1,294,132, and $1,357,873 respectively.

A detailed fund-raising strategy has been approved by the Foundation [see Attachment 6]. A major campaign, headed by a distinguished local Honorary Chairman, Alex Colville, C.C., P.C., will begin as soon as possible, and involve professional assistance; however, the administrative cost of the campaign should be between 5% and 10% of income, not to exceed $75,000. Appeals for donations will stress the importance of multi-year pledges and will focus on Foundations, service clubs, business organizations, the 83 churches in the county, and individuals. There are plans to seek donations of material, labour, equipment, and furniture during the construction stage. An informative web site is being planned and will be operative by the time the financial campaign begins.

In summary, the Working Group believes that a ten-bed, free-standing, fully equipped Hospice can be built on the Valley Regional Hospital site without direct financial assistance from the government. However, government support will be essential to operate the facility. That support will need to amount to approximately 95% of the annual cost.

Palliative care services received in homes and in Valley Regional Hospital

during the calendar year 2000 have been documented with the following results: 156 patients were seen by the Palliative Care nurse in the hospital and a further 187 were assisted through the VON, either through the nursing/home support or the volunteer programme. Valley Regional Hospital records indicate that on any given day there are between three and six in-patients who would probably be in a hospice, should one exist. The nurses responsible for the palliative care service, either in the hospital or through the VON, estimate that of the 343 identified patients/clients 205 might have used the services of a Hospice for one or more of the following:

Respite care	120
End of Life care	164
Bereavement follow-up	150
Supportive services	205

When interpreting the above statistics, it should be borne in mind that some patients received palliative care in their homes as well as in the hospital; similarly, some of those patients who receive palliative care in their homes might also use the Hospice services as day-patients.

There appears to be no definitive per diem cost for patients in the Valley Regional Hospital. Some years ago, the former Western Regional Health Board

(WRHB) was given a figure of $1,350 a day. More recently the average per diem cost for all the facilities operated by the AVDHA was calculated to be $1,133. The AVDHA uses $700 as the per diem charge for uninsured hospital stays. The estimated average daily cost for an in-patient in the Hospice operating at full capacity in year three would be $392. This figure ignores the services rendered to the day-patients. Comparative data from small Canadian Hospices are difficult to interpret because the differing Hospices are supported in different ways by different funding sources. Information from 1997 indicates the following costs:

Cottage Hospice, Vancouver	10-bed	$275 per day
Rosedale Hospice, Calgary	7-bed	$350 per day
Casey House, Toronto	13-bed (HIV or AIDS)	$670 per day

According to a document published by the Hospice Association of America in 1997, the in-patient day rate covered by Medicare in a free-standing Hospice was $419 (USD). Per diem costs for long term care facilities, released by the Department of Health in April 2001, range from a low of $88 to a high of $265, with a mean of $129 [see Attachment 7].

In passing, we may note that hospices in Canada apply different admissions criteria and some specialize in particular patient conditions; consequently it is

difficult to calculate an average length of stay. However, in general terms the national average length of patient stay is probably 18-21 days.

Further support for the contribution that might be made by the establishment of a Hospice in the Valley is provided by data included in the Report of the Clinical Services Steering Committee (February 2001). The report indicates that there are 68 respite beds in the province, of which only two are in DHA 3 (These are located in the Annapolis Royal Health Centre). There is also a significant shortfall in DHA 3 in the number of long-term care beds per 1000 of the population over the age of 75 years (only DHA 4 has fewer beds). The Health Action Coalition of Kings has compared the number of weighted cases (a score derived from the complexity of cases and the resources utilized) and the number of hospital beds per 1000 population; the average weighted case in DHA 3 has a much higher complexity level than the rest of the province. Despite this complexity the report of the Clinical Services Steering Committee (February 2001) documents that among the nine District Health Authorities, the Annapolis Valley District Health Authority has the lowest separation rate per 1000 resident population, and the second lowest rate of acute days per separation in the fiscal year 1998-99. The Coalition suggests that it is particularly difficult in the catchment area of the proposed Hospice to admit or care for the needs of patients who would be best cared for in a Hospice. "Despite the best possible

clinical care and the best will in the world, it is not possible for a stressed and harried medical care team to provide appropriate emotional and psychological support to the dying patient and his or her family in the prevailing acute clinical care setting." The Working Group believes that a Hospice can provide the appropriate support in a dignified and understanding environment, and at the same time relieve hospital staff of the demands of offering palliative care.

The Working Group strongly endorses government policy to provide a complete continuum of care. The lack of hospice facilities in this area constitutes a serious gap in the range of care that is available. There can be no "continuum of care" until that gap is filled. The proposal to build, equip and furnish a ten-bed, free-standing hospice and to defray the costs through voluntary contributions is a worthy aim and there is considerable confidence that this can be done within a matter of months.

To date, this initiative has been carried forward largely through the work of many dedicated volunteers and it is expected that once the facility is operative even more volunteers will come forward to help in a variety of ways. We urge the government of Nova Scotia to endorse and support the proposal while the interest level remains high and is expressed in the most practical terms.

The Minister's Working Group therefore recommends to the Minister of Health:

That the Government of Nova Scotia agree to provide 95 percent of the operating costs of the VON Kings Hospice to be built and equipped by voluntary contributions.

VON Hospice
Draft Budget (Year 1)

Revenue	Per Diem (Day Hospice Program)	*	101,400.00
	Hospice Foundation Funding (5%)		53,200.67
	Provincial Funding		1,010,812.77
			1,165,413.44
Expense	Salaries	*	651,830.40
	Benefits		100,932.54
	Contracted Staff		100,210.50
	Direct Program Costs		128,540.00
	Operational Costs		183,900.00
			1,165,413.44
Total Operating Surplus (Deficit)			0.00

Cost Analysis

Day Program

* This figure represents the per diem rate paid through the government program established to fund Adult Day Services. It is based on $65. per client, per day which is the high end figure submitted to the Department of Health in Feb 1998 by the Adult Day Network in their funding proposal entitled, "Supportive Funding Requirements for Adult Day Programs in Nova Scotia."

Salaries & Benefits

* Throughout this projected budget the salaries for the RN's and LPN's - reflect the scale as determined by the Arbitrator's selected in August 2001.

Draft Budget - Hospice
Staff Costs

b2

	Hourly Rate	Increments Rate	Increments Month	Total Salary	WCB	CPP	EI	Pension	Group Ins
MANAGEMENT & OPERATIONAL SUPPORT									
Hospice Manager	28.51			55,594.50	1,283.85	1,329.90	1,226.16	2,771.67	1,278.67
Secretary / Receptionist	13.06			25,467.00	807.30	856.71	800.68	1,146.02	585.74
Educational Coordinator	14.18			5,530.20	175.31	79.18	173.87	248.86	127.19
Social Worker	23.80			27,846.00	882.72	949.49	875.48	1,253.07	640.46
Coordinator of Volunteers (RN)	27.17			21,192.60	671.81	690.01	666.30	953.67	487.43
Subtotal				135,630.30	3,820.99	3,905.29	3,742.49	6,373.29	3,119.49
DIRECT SERVICE PROVIDERS									
RN 1 (BN)	27.17			52,981.50	1,283.85	1,329.90	1,226.16	2,614.89	1,218.57
RN 2 (BN)	27.17			52,981.50	1,283.85	1,329.90	1,226.16	2,614.89	1,218.57
RN 3 (BN)	27.17			52,981.50	1,283.85	1,329.90	1,226.16	2,614.89	1,218.57
RN 4 (BN)	27.17			52,981.50	1,283.85	1,329.90	1,226.16	2,614.89	1,218.57
RN 5	25.46			49,647.00	1,283.85	1,329.90	1,226.16	2,414.82	1,141.88
RN 6	25.46			24,823.50	786.90	831.62	780.45	1,117.06	570.94
PCW / Housekeeping 1	11.80			23,010.00	729.42	760.89	723.43	1,035.45	529.23
PCW / Housekeeping 2	11.80			23,010.00	729.42	760.89	723.43	1,035.45	529.23
PCW / Housekeeping 3	11.80			23,010.00	729.42	760.89	723.43	1,035.45	529.23
PCW / Housekeeping 4	11.80			23,010.00	729.42	760.89	723.43	1,035.45	529.23
PCW / Housekeeping 5	11.80			23,010.00	729.42	760.89	723.43	1,035.45	529.23
PCW / Housekeeping 6	11.80			23,010.00	729.42	760.89	723.43	1,035.45	529.23
Day Program Coordinator	17.36			27,081.60	858.49	919.68	851.45	1,218.67	622.88
Day Program Assistant	11.80			13,806.00	437.65	401.93	434.06	621.27	317.54
Home Support / Dietary Services	11.80			23,010.00	729.42	760.89	723.43	1,035.45	529.23
Pastoral Counselor	23.80			27,846.00	882.72	949.49	935.63	1,253.07	640.46
Subtotal				516,200.10	14,490.95	15,078.45	14,196.40	24,332.60	11,872.59
Total				**651,830.40**	**18,311.94**	**18,983.74**	**17,938.89**	**30,705.89**	**14,992.08**

Draft Budget - Hospice
Contracted Staff Costs

b3

	April Hourly Rate	Increment Rate	Increment Month	Total Salary	WCB	CPP	EI	Pension	Group Ins
Contracted Services									
Complementary Therapists	50.00			48,750.00	-	-	-	-	-
Medical Consultant	51.30			30,010.50	-	-	-	-	-
Maintenance	22.00			21,450.00	-	-	-	-	-
Total	50.00			100,210.50					

Draft Budget - Hospice
Non-Salary Costs

Direct Program Costs		
Residential Care Costs:		
Nursing / Personal Supplies	7,300	
Equipment Purchases	2,000	9,300
Medication		65,000
Transportation (Day Program)		15,600
Dietary Service Costs:		
Residents	26,280	
Day Clients	9,360	
Family Meeting Supplies	2,000	
Kitchen Supplies	1,000	38,640
Total Direct Program Costs		128,540
Operational Costs		
Facility Costs:		
Taxes	30,000	
Water & Sewer	2,000	
Telephone	5,000	
Cable TV	4,000	
Power	6,000	
Insurance	4,000	51,000
Housekeeping Costs		
Supplies	3,500	
Equipment	600	4,100
Administrative Expenses		
Telephone	9,000	
Postage	3,500	
Stationary & Supplies	4,800	
Printing	5,000	
Equipment Rental	6,000	28,300
Administrative Expense		75,000
Staff / Volunteer Mileage		6,300
Staff / Volunteer Education		7,200
Program Costs		
Volunteers	2,400	
Day Program	4,800	
Bereavement	2,400	
Library Acquisitions	1,200	
Hospice Membership Fees	1,200	12,000
Total Operational Costs		183,900

Draft Budget - Hospice (Year 1)
Administrative Assumptions

Hours Paid Per Day		7.5
CPP Employee %		3.90%
EI Employee %		2.40%
Employer Contribution FT/PT		1.31
Employer Contribution Casual		1.40
WCB Rate per Hundred	$	3.17
CPP Ceiling	$	37,600.00
CPP Excluded Amount	$	3,500.00
EI Ceiling	$	39,000.00
WCB Ceiling	$	40,500.00
Committee Time per FTE - Direct Service Provider		2 days
Sick Time per FTE - Direct Service Provider		5 days
Paid Education Time per FTE - Direct Service Provider		3 days
Statutory Holidays per FTE - Direct Service Provider		11 days
Committee Time per FTE - Admin & Support		2 days
Sick Time per FTE - Admin & Suppport		6 days
Paid Education Time per FTE - Admin & Support		3 days

VON Hospice
Draft Budget (Year 2)

Revenue	Per Diem (Day Hospice Program)	135,200.00
	Hospice Foundation Funding (.5%)	68,112.22
	Provincial Funding	1,294,132.21
		1,497,444.43
Expense	Salaries	887,355.30
	Benefits	139,988.68
	Contracted Staff	109,728.45
	Direct Program Costs	165,438.00
	Operational Costs	194,934.00
		1,497,444.43
Total Operating Surplus (Deficit)		0.00

Cost Analysis

Day Program

- This figure represents the per diem rate paid through the government program established to fund Adult Day Services. It is based on $65. per client, per day which is the high end figure submitted to the Department of Health in Feb 1998 by the Adult Day Network in their funding proposal entitled, "Supportive Funding Requirements for Adult Day Programs in Nova Scotia."

Salaries and Benefits

Throughout this projected budget the salaries for the RN's and LPN's - reflect the scale as determined by the Arbitrator's selected in August 2001.

Staff Cost

	Hourly Rate	Increments Rate	Increments Month	Total Salary	WCB	CPP	EI	Pension	Group Ins
MANAGEMENT & OPERATIONAL SUPPORT									
Hospice Manager	29.93			58,363.50	1,336.50	1,329.90	1,226.16	2,937.81	1,342.36
Secretary / Receptionist	13.71			26,734.50	882.24	906.15	840.53	1,203.05	614.89
Educational Coordinator	25.38			9,898.20	326.64	249.53	311.20	445.42	227.66
Social Worker	24.99			29,238.30	964.86	1,003.79	919.25	1,315.72	672.48
Coordinator of Volunteers (RN)	28.32			22,089.60	728.96	724.99	694.50	994.03	508.06
Subtotal				146,324.10	4,239.20	4,214.36	3,991.64	6,896.03	3,365.45
DIRECT SERVICE PROVIDERS									
RN 1 (BN)	28.32			55,224.00	1,336.50	1,329.90	1,226.16	2,749.44	1,270.15
RN 2 (BN)	28.32			55,224.00	1,336.50	1,329.90	1,226.16	2,749.44	1,270.15
RN 3 (BN)	28.32			55,224.00	1,336.50	1,329.90	1,226.16	2,749.44	1,270.15
RN 4 (BN)	28.32			55,224.00	1,336.50	1,329.90	1,226.16	2,749.44	1,270.15
RN 5	26.73			52,123.50	1,336.50	1,329.90	1,226.16	2,563.41	1,198.84
RN 6	26.73			26,061.75	860.04	879.91	819.38	1,172.78	599.42
LPN 1	18.49			36,055.50	1,189.83	1,269.66	1,133.58	1,622.50	829.28
LPN 2	18.49			36,055.50	1,189.83	1,269.66	1,133.58	1,622.50	829.28
LPN 3	18.49			36,055.50	1,189.83	1,269.66	1,133.58	1,622.50	829.28
LPN 4	18.49			36,055.50	1,189.83	1,269.66	1,133.58	1,622.50	829.28
LPN 5	18.49			36,055.50	1,189.83	1,269.66	1,133.58	1,622.50	829.28
LPN 6	18.49			18,027.75	594.92	566.58	566.79	811.25	414.64
PCW / Housekeeping 1	12.20			23,790.00	785.07	791.31	747.96	1,070.55	547.17
PCW / Housekeeping 2	12.20			23,790.00	785.07	791.31	747.96	1,070.55	547.17
PCW / Housekeeping 3	12.20			23,790.00	785.07	791.31	747.96	1,070.55	547.17
PCW / Housekeeping 4	12.20			23,790.00	785.07	791.31	747.96	1,070.55	547.17
PCW / Housekeeping 5	12.20			23,790.00	785.07	791.31	747.96	1,070.55	547.17
PCW / Housekeeping 6	12.20			23,790.00	785.07	791.31	747.96	1,070.55	547.17
Day Program Coordinator	18.49			28,844.40	951.87	988.43	906.87	1,298.00	663.42
Day Program Assistant	12.20			19,032.00	628.06	605.75	598.37	856.44	437.74
Home Support / Dietary Services	12.20			23,790.00	785.07	791.31	747.96	1,070.55	547.17
Pastoral Counselor	24.99			29,238.30	964.86	1,003.79	982.41	1,315.72	672.48
Subtotal				741,031.20	22,126.89	22,581.43	20,908.24	34,621.71	17,043.73
Total				**887,355.30**	**26,366.09**	**26,795.79**	**24,899.88**	**41,517.74**	**20,409.18**

Draft Budget - Hospice (Year 2)
Contracted Staff Costs

	April Hourly Rate	Increment Rate	Increment Month	Total Salary 1999/00	WCB	CPP	EI	Pension	Group Ins
Contracted Services									
Complementary Therapists	52.50			51,187.50	-	-	-	-	-
Medical Consultant	53.87			31,513.95	-	-	-	-	-
Maintenance	23.10			27,027.00	-	-	-	-	-
Total	50.00			109,728.45					
	1.05								

Draft Budget - Hospice (Year 2)
Non-Salary Costs

Direct Program Costs		
Residential Care Costs:		
Nursing / Personal Care Supplies	7,738	
Equipment Purchases	4,000	11,738
Medication		81,000
Transportation (Day Program)		20,800
Dietary Service Costs:		
Residents	36,000	
Day Clients	12,500	
Family Meeting Supplies	2,200	
Kitchen Supplies	1,200	51,900
Total Direct Program Costs		165,438
Operational Costs		
Facility Costs:		
Taxes	31,800	
Water & Sewer	2,120	
Telephone	5,300	
Cable TV	4,240	
Power	6,360	
Insurance	4,240	54,060
Housekeeping Costs		
Supplies	3,710	
Equipment	636	4,346
Administrative Expenses		
Telephone	9,540	
Postage	3,710	
Stationary & Supplies	5,088	
Printing	5,300	
Equipment Rental	6,360	29,998
Administrative Expense		79,500
Staff / Volunteer Mileage		6,678
Staff / Volunteer Education		7,632
Program Costs		
Volunteers	2,544	
Day Program	5,088	
Bereavement	2,544	
Library Acquisitions	1,272	
Hospice Membership Fees	1,272	12,720
Total Operational Costs		194,934

Draft Budget - Hospice (Year 2)
Administrative Assumptions

Hours Paid Per Day	7.5
CPP Employee %	3.90%
EI Employee %	2.40%
Employer Contribution FT/PT	1.31
Employer Contribution Casual	1.40
WCB Rate per Hundred	$ 3.30
CPP Ceiling	$ 37,600.00
CPP Excluded Amount	$ 3,500.00
EI Ceiling	$ 39,000.00
WCB Ceiling	$ 40,500.00
Committee Time per FTE - Direct Service Provider	2 days
Sick Time per FTE - Direct Service Provider	5 days
Paid Education Time per FTE - Direct Service Provider	3 days
Statutory Holidays per FTE - Direct Service Provider	11 days
Committee Time per FTE - Admin & Support	2 days
Sick Time per FTE - Admin & Suppport	6 days
Paid Education Time per FTE - Admin & Support	3 days

VON Hospice
Draft Budget (Year 3)

Revenue	Per Diem (Day Hospice Program)	*	169,000.00
	Hospice Foundation Funding (5%)		71,466.99
	Provincial Funding		1,357,872.80
			1,598,339.79
Expense	Salaries	*	921,675.30
	Benefits		146,631.94
	Contracted Staff		124,388.55
	Direct Program Costs		199,676.00
	Operational Costs		205,968.00
			1,598,339.79
Total Operating Surplus (Deficit)			0.00

Cost Analysis

Day Program

* This figure represents the per diem rate paid through the government program established to fund Adult Day Services. It is based on $65. per client, per day which is the high end figure submitted to the Department of Health in Feb 1998 by the Adult Day Network in their funding proposal entitled, "Supportive Funding Requirements for Adult Day Programs in Nova Scotia."

Salaries and Benefits

Throughout this projected budget the salaries for the RN"s and LPN's - reflect the scale as determined by the Arbitrator's selected in August 2001.

Draft Budget - Hospice (Year 3)
Staff Costs

	Hourly Rate	Increments Rate	Increments Month	Total Salary	WCB	CPP	EI	Pension	Group Ins
MANAGEMENT & OPERATIONAL SUPPORT									
Hospice Manager	29.93			58,363.50	1,385.10	1,329.90	1,226.16	2,937.81	1,342.36
Secretary / Receptionist	14.37			28,021.50	958.34	956.34	881.00	1,260.97	644.49
Educational Coordinator	26.18			10,210.20	349.19	261.70	321.01	459.46	234.83
Social Worker	25.29			29,589.30	1,011.95	1,017.48	930.29	1,331.52	680.55
Coordinator of Volunteers (RN)	28.60			22,308.00	762.93	733.51	701.36	1,003.86	513.08
Subtotal				148,492.50	4,467.51	4,298.93	4,059.82	6,993.62	3,415.31
DIRECT SERVICE PROVIDERS									
RN 1 (BN)	28.60			55,770.00	1,385.10	1,329.90	1,226.16	2,782.20	1,282.71
RN 2 (BN)	28.60			55,770.00	1,385.10	1,329.90	1,226.16	2,782.20	1,282.71
RN 3 (BN)	28.60			55,770.00	1,385.10	1,329.90	1,226.16	2,782.20	1,282.71
RN 4 (BN)	28.60			55,770.00	1,385.10	1,329.90	1,226.16	2,782.20	1,282.71
RN 5	26.99			52,630.50	1,385.10	1,329.90	1,226.16	2,593.83	1,210.50
RN 6	26.99			26,315.25	899.98	889.79	827.35	1,184.19	605.25
LPN 1	18.85			36,757.50	1,257.11	1,297.04	1,155.66	1,654.09	845.42
LPN 2	18.85			36,757.50	1,257.11	1,297.04	1,155.66	1,654.09	845.42
LPN 3	18.85			36,757.50	1,257.11	1,297.04	1,155.66	1,654.09	845.42
LPN 4	18.85			36,757.50	1,257.11	1,297.04	1,155.66	1,654.09	845.42
LPN 5	18.85			36,757.50	1,257.11	1,297.04	1,155.66	1,654.09	845.42
LPN 6	18.85			18,378.75	628.55	580.27	577.83	827.04	422.71
PCW / Housekeeping 1	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
PCW / Housekeeping 2	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
PCW / Housekeeping 3	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
PCW / Housekeeping 4	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
PCW / Housekeeping 5	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
PCW / Housekeeping 6	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
Day Program Coordinator	18.85			36,757.50	1,257.11	1,297.04	1,155.66	1,654.09	845.42
Day Program Assistant	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
Home Support / Dietary Services	12.99			25,330.50	866.30	851.39	796.39	1,139.87	582.60
Pastoral Counselor	25.29			29,589.30	1,011.95	1,017.48	994.20	1,331.52	680.55
Subtotal				773,182.80	23,939.04	23,730.40	21,835.26	36,108.88	17,783.17
Total				**921,675.30**	**28,406.55**	**28,029.33**	**25,895.08**	**43,102.50**	**21,198.48**

Draft Budget - Hospice (Year 3)
Contracted Staff Costs

	April Hourly Rate	Increment Rate	Increment Month	Total Salary	WCB	CPP	EI	Pension	Group Ins
Contracted Services									
Complementary Therapists	55.00			53,625.00	-	-	-	-	-
Medical Consultant	56.43			33,011.55	-	-	-	-	-
Maintenance	24.20			37,752.00	-	-	-	-	-
Total	50.00			124,388.55					
	1.10								

Draft Budget - Hospice (Year 3)

b14

Non-Salary Costs

Direct Program Costs		
Residential Care Costs:		
Nursing / Personal Care Supplies	8,176	
Equipment Purchases	4,000	12,176
Medication		98,000
Transportation (Day Program)		26,000
Dietary Service Costs:		
Residents	44,000	
Day Clients	15,700	
Family Meeting Supplies	2,400	
Kitchen Supplies	1,400	63,500
Total Direct Program Costs		199,676
Operational Costs		
Facility Costs:		
Taxes	33,600	
Water & Sewer	2,240	
Telephone	5,600	
Cable TV	4,480	
Power	6,720	
Insurance	4,480	57,120
Housekeeping Costs		
Supplies	3,920	
Equipment	672	4,592
Administrative Expenses		
Telephone	10,080	
Postage	3,920	
Stationary & Supplies	5,376	
Printing	5,600	
Equipment Rental	6,720	31,696
Administrative Expense		84,000
Staff / Volunteer Mileage		7,056
Staff / Volunteer Education		8,064
Program Costs		
Volunteers	2,688	
Day Program	5,376	
Bereavement	2,688	
Library Acquisitions	1,344	
Hospice Membership Fees	1,344	13,440
Total Operational Costs		205,968

Draft Budget - Hospice (Year 3)
Administrative Assumptions

Hours Paid Per Day		7.5
CPP Employee %		3.90%
EI Employee %		2.40%
Employer Contribution FT/PT		1.31
Employer Contribution Casual		1.40
WCB Rate per Hundred	$	3.42
CPP Ceiling	$	37,600.00
CPP Excluded Amount	$	3,500.00
EI Ceiling	$	39,000.00
WCB Ceiling	$	40,500.00
Committee Time per FTE - Direct Service Provider		2 days
Sick Time per FTE - Direct Service Provider		5 days
Paid Education Time per FTE - Direct Service Provider		3 days
Statutory Holidays per FTE - Direct Service Provider		11 days
Committee Time per FTE - Admin & Support		2 days
Sick Time per FTE - Admin & Suppport		6 days
Paid Education Time per FTE - Admin & Support		3 days

HOSPICE BUDGET NOTES:

Management and Operational Support:

Hospice Manager
This is a full time position to be filled by an individual with skills in administration, preferably an RN.

Secretary
This is a half time position (Monday-Friday)

Educational Coordinator
This person will be an RN and will coordinate education for Hospice staff, other professionals and members of the community.

Social Worker
This position will be filled by a registered Social Worker who will work with individuals and family units to address areas of concern *re* finances, legal matters, housing etc.

Coordinator of Volunteers
This position will be filled by an RN .This position may be combined with an existing position in the community to make one full time position

Direct Service Providers:
The ratio of residents to direct care providers is 3 to 1

RNs
The Hospice will have 24 hour RN coverage provided in three shifts per day. The salaries budgeted reflect the scale as determined by the Arbitrator's selection in August 2001.

LPNs
LPNs will be used on heavy care shifts to support care to the residents and family members. The salaries budgeted reflect the scale as determined by the Arbitrator's selection in August 2001.

PCW/Housekeeping (CCAs)
These positions will be filled by Continuing Care Assistants (formerly known as Home Support Workers) who have been trained in personal care, housekeeping and meal preparation. Their duties will be defined by the needs of the Hospice residents.

The ratio of clients to direct care providers in the day Hospice is 5 to 1.

Day Program Coordinator

The budget for this position allows for the hiring of an LPN with skills in programming. This program will start three days per week and will add an additional day in the second and third year.

Day Program Assistant
The Day Hospice Assistant is budgeted at the level of a CCA (HSW).

Pastoral Counsellor
This person will assist individuals, families and staff by providing spiritual support. The salary scale is based on that of the other professional staff.

Contracted Services:

Complementary Therapists
The complementary therapists include all forms of therapies including but not limited to massage therapy, aromatherapy and music therapy. This figure also includes arrangements for more conventional therapies such as occupational therapy, physiotherapy and psychotherapy.

Medical Consultant
This is anticipated to be a shared position to ensure 24 hour access to a physician. This position is not designed to provide direct service which is anticipated to be an insurable expense of each attending physician but rather to be a resource to the Hospice staff and the family physicians regarding pain and symptom management, hydration etc.

Maintenance
The figure budgeted for maintenance is one half of a position contracted through Valley Regional Hospital. This figure includes someone to provide routine maintenance to the facility as well as snow removal and lawn care.

Direct Program Costs:

Residential Care Costs: (Based on an estimate of 80% usage in the first year, and 100% in each subsequent year)

Nursing / Personal Care Supplies
Estimated cost per day at $20.00
$20.00 x 300 days = 6000.00 (Year 1)
$20.00 x 365 days = 7300.00 (Years 2 and 3)

Equipment Purchase
It is anticipated that most equipment will be donated; however, in the event that equipment must be purchased in the first year a nominal amount of $2000.00 has been budgeted.
For years 2 and 3 the budget reflects $4000.00 per year for new equipment.

Medication
A study was conducted into the cost of medication used by palliative patients receiving Home Care in Kings County and receiving care in Valley Regional Hospital. The detailed results of that study have been retained as supporting documents. To arrive at a cost for medications the figure of the combined settings was used and an additional amount was added as a dispensing fee. In addition, the budget reflects the use of the CADD pump by one patient per week at the maximum projected dosage.
Year 1 estimated cost $177.60 per day (22.10 x 6 =132.60 + 45=177.60)
$177.60 x 300=$ 53,280.00
Year 2 estimated cost $221.80 per day (22.10 x 8 =176.80 + 45 = 221.80)
$ 221.80 x 365 = $ 80,957.00.
Year 3 estimated cost of $266 per day (22.10 x 10 = 221.00 + 45 = $266)
$266 x 365 = $97,090.00

Based on VON figures of persons having a drug plan the budget reflects that 35% of clients will have coverage for medication.
Year 1 revenue – $18,648.00
Year 2 revenue - $28,335.00
Year 3 revenue - $33,981.00

Transportation - Day Hospice
Estimated at $10 per day per client (Based on current cost of service through Kings County Alternative Transportation Society)
Year 1 ($10 x 10 clients x 156 days = $15,600)
Year 2 ($10 x 10 clients x 208 days =$ 20,800)
Year 3 ($10 x 10 clients x 260 days= $ 26,000)

Dietary Service Costs:
The cost of food for Hospice residents is budgeted at $2.00 per breakfast, $ 4.00 per lunch and $ 6.00 per dinner for a total of $ 12.00 per day.
Year 1 (12.00 x 6 x 300 = 21,600.00)
Year 2 (12.00 x 8 x 365 = 35,040.00)
Year 3 (12.00 x 10 x 365= 43,800.00)

Day Hospice Clients ($ 6.00 per day x 10 clients x156 days = $9360)

Operational Costs:
Facility costs:

Taxes
Given assessed rate of land at a value of $60,000 plus an assessed value of the building of $800,000. Tax rate based on 1,000,000. (10,000 sq ft x 2.98 = $29,800)

Water & Sewer
Estimated at 300,000 gallons per year. Household of 2-3 = 48,000 gallons x 5 = 240,000. Daily laundry, washing and cleaning needs reflect the special nature of a hospice.
Water: $25.74 per month ($25.74 x 12 = $308.88)
$2.75 per 1,000 gallons ($2.75 x 300 = $825)
Sewer: $19.26 per month (19.26 x 12 = $231.12)
$1.67 per 1,000 gallons ($1.67 x 300 = $501)
All figures and estimates based on information obtained from the Town of Kentville at Current water and sewer rates.

Telephone (Patients)
Estimated at 1 telephone per client room. Monthly rental of phones $15 plus $25 per month for service.

Year 1 ($40 x 6 = $240 x 12 = $2880) rounded to $3,000
Year 2 ($40 x 8= $320 x 12 = $3840) rounded to $4,000
Year 3 ($40 x 10=$400 x 12 = $4800) rounded to $5,000

Cable TV
Estimated 8 TVs @ $40 month for service = $3840 rounded to $4000

Power
Based on current rate information and general charges (given building size and usage) NS Power estimated conservatively at 4,200 per year. This figure was rounded up to $6000 to include business office, kitchen equipment, laundry and general office equipment.

Insurance
An estimate of $4000.00 was given based on the construction of a brick building with sprinkler system and $300,000 worth of contents.
This would also include liability insurance and coverage for contents (documents). Until a more detailed understanding of the building and its features is developed this is STRICTLY

a ballpark figure.

Housekeeping Supplies
The estimate of 4100.00 for housekeeping supplies and equipment is based on the assumption that those supplies could be purchased through VRH at a reduced cost.

Administrative Expenses:

Telephone (Staff)

The cost of telephone service for staff is estimated at $ 8000.00
This includes 10 telephones (given projected staffing levels). Each phone would include a Monthly rental charge and voice mail.
($15 rental + $25 service + $ 10 v mail x 10 phones = $500 x 12 = $6,000)
Also added Internet expenses ($40 x 12 = $480 used $500)
Included an additional fee for long distance charges or toll free capability at a cost of $1,500.

Postage
The postage rate of $3500.00 per year is based on average usage of VON Annapolis Valley . This includes 4,000 pieces of mail at various sizes and weight. The budget figure also includes use of a courier for certain items.

Stationery & Office Supplies
The figure of $ 4800.00 for Year 1 is based on average usage of VON Annapolis Valley and given first year initial buying and need for supplies.
Year 2 $ 4000.00
Year 3 $ 4000.00

Printing
The estimate of $5000.00 for printing includes the initial cost of producing brochures, forms, letterhead and envelopes. The cost for Year 2 and 3 is also projected at $ 5000.00 each as training programs for staff and volunteers will require additional printing.

Equipment Rental
Included $300 per year for postage machine and $450 per month for photocopier. It is anticipated that the lease will include hidden charges such as toner and a proper copier limit so as to not exceed budgeted copier lease projection.

Administrative Costs
This is included in the $75,000 administrative expense provided by VON Canada NS. The is estimate is based on standard costs for VON Canada administrative services which include supervision,banking, billing, auditing, accounting, payroll, etc.

Staff / Volunteer Mileage
Budget for 20,000 km per year at a rate of .315 per km.

HOSPICE BUDGET NOTES (Year 2):

Estimated a 6% increase in all Non-Salary expenses.
Estimated a 5% increase for all Salaried expenses.

Added one LPN at .80
Added another PCW at .50
Increase WCB rate by 4% - All other assumptions remained the same.

Increased maintence needs to .6 from .5

HOSPICE BUDGET NOTES (Year 3):

Estimated a 6% increase in all Non-Salary expenses.

Increased one PCW to 1.00 from .5
Increase WCB rate by 4% - All other assumptions remained the same.

Increased maintence needs to .8 from .6

List of Attachments

1. *Mind, Body and Soul:*
   Exploring the Need for a Hospice in Kings County
   (Needs Assessment)

2. *Hospice Feasibility Study*

3. Site Plan

4. MacMillan Green Hospice Plan

5. Letter From Chair of AVDHA

6. Fundraising Strategy

7. Per Diem Costs of Long Term Care

8. Letters of Support

Mind, Body, and Soul:
Exploring The Need For A Hospice In Kings County

Prepared for: VON Kings Branch

By Dr. Jeanette A. Auger
and Alison R. Bursey

October, 1997

Care lies at the heart of the hospice. It says we are here. We will be with you in your living and your dying. We will free you from your pain and give you the freedom to find your own meaning in your life - your way. We will comfort you and those you love - not always with words, often with a touch or a glance. We will bring you hope - not for tomorrow but for this day. We will not leave you. We will watch with you. We will be there.

Dorothy Ley

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Acknowledgments

There are many people who, over the past six months, were instrumental in the completion of this needs assessment.

I wish to extend thanks to the caregivers, families, friends and significant others who participated in this study and shared their personal experiences in an effort to enhance the understandings of the needs and wants of palliative care clients in Kings County; none of this would be possible without you...

I wish to acknowledge the valuable assistance, advice and input the Palliative Care Advisory Committee has provided.

I am indebted to the support and assistance of the staff at the VON, Kings Branch. Specifically, I would like to extend gratitude to Brenda Allen. Angela Fraser, Jane Davison-Weir and Shelly Ogden. Furthermore, working with the VON on this needs assessment has provided me with the opportunity to learn and practice my research skills in my own community.

As well, acknowledgment of the financial support provided through VON Canada and Western Kings Memorial Health Board has been significantly appreciated.

On a more personal basis, I thank my mother, my partner and friends for supporting me through this experience. A special thank-you goes to my friend and co-worker Jeanette Auger for her support and encouragement, as well as her professional advice. Finally, I extend my appreciation to Robin Arenburg for her many helpful comments, suggestions and editing expertise.

Acknowledgements

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Mind, Body, and Soul:
Exploring The Need For A Hospice In Kings County

Executive Summary

Executive Summary

This report represents the findings from three interconnected stages of research:

1. Focus group meeting with individuals representing the following agencies: VON, HomeCare Nova Scotia, Eastern Kings Memorial Health Centre, Valley Regional Hospital, Valley AIDS Concern Group, Acadia University and palliative care volunteers
2. Visiting free-standing hospices in the United Kingdom
3. Needs Assessment

During the past twenty years, palliative care has emerged as a new and significant component in the continuum of health care services in Canada. Palliative care focuses on the relief of symptoms and pain control, and provides emotional, social, spiritual and informational support to patients and their families. The first Canadian palliative care programs were introduced to Montreal and Winnipeg in 1975, with the first free-standing hospice founded in Toronto, Ontario, under the leadership of June Callwood in 1983. Since then, the number of palliative care programs has risen dramatically. According to the *1997 Canadian Directory of Services: Palliative Care and HIV/AIDS*, there are 594 palliative care programs in Canada. Located in both urban and rural settings throughout ten provinces and two territories, these programs seek to fulfill many of the needs of each community with respect to dealing with life threatening illnesses.

Every community has been and will be faced with the challenge of caring for individuals facing terminal illnesses as life expectancy and chronic disease increase and, with the continuing spread of serious viruses such as HIV/AIDS. It is the responsibility of every community to review its resources and prepare for an increase in the number of individuals faced with life threatening ailments.

This document reports on a needs assessment for a hospice in Kings County. The objectives of this research were twofold; firstly, to identify the unmet physical, psychological, social, spiritual, informational and financial needs of individuals faced with a life threatening illness and their caregivers. Secondly, to determine the need for a hospice facility in Kings County.

A mail-survey and interview format method was adopted for this study. In total, 374 individuals were approached to participate in the needs assessment. One hundred and fourteen (114) returned the questionnaire and an additional 10 people were interviewed. The response rate for this study was 33%. The sample population was selected from groups of persons who were knowledgeable about palliative care clients. Participation in the study was voluntary.

The sample consisted of the following groups:

- Individuals with a life threatening illness, their families and significant others;
- Formal care providers: VON nurses, LPNs, care coordinators and home support workers, physicians, clergy and alternative health practitioners; and
- Informal care providers: VON/PEP Palliative and Supportive Volunteers, Friends of Bereavement Support Group, Living With Cancer Support Group and Valley AIDS Concern Group.

Some concerns identified by those who participated in this needs assessment were as follows:

- Care is fragmented. Services and programs are not coordinated and integrated. This has resulted in poor communication between local health care providers
- Care needs to be provided 24 hour care, 7 days a week
- Approach to care is not holistic. Emphasis is on meeting physical needs with little attention to the psychological, social, spiritual, informational and financial needs
- Assessment procedures of Home Care Nova Scotia needs to be standardized
- Care is crisis oriented and not preventive
- Medical equipment, supplies and prescription are difficult to obtain
- Not enough respite care available in the home
- Too many health care providers entering the home
- Hospitalization is the only option when support and finances are insufficient
- Hospital is not the appropriate place for care because the focus is on acute not palliative care
- No assistance or training for families or significant others with the transition phase from hospital to home
- Inadequate training of health professionals in palliative care
- Inadequate education of physicians in pain & symptom control management
- Difficulty contacting health care providers, especially physicians
- Poor public relations on the care that is available. There is no central point for all information
- Programs and services that are offered are not sufficiently flexible
- The community is not aware of existing programs and services for palliative care clients
- Not enough funding provided to existing programs and services for palliative care
- No follow-up care for family or significant others after a lengthy illness of a loved one

An overwhelming portion of the sample (87%) felt there was a need for a free-standing hospice facility in Kings County. Only one percent felt there was no need for a hospice and twelve percent did not know.

Just eighteen percent of the population reported they would not support the concept of a hospice and eighty-two percent would support the concept of a hospice if one was made available.

alliative care strives to fulfill the total holistic needs of those dealing with life threatening illnesses, as well as those who care for them. The physical, psychological, social, spiritual, informational and financial needs of the dying and those whose care for them need to be met. The body, mind and soul of humans are not separate entities that can be divided and cared for separately. This needs assessment has indicated palliative care programs and services in Kings County are not addressing all the needs of the dying and their care providers. The programs and services that provide palliative care need to address concerns around lack of integration and coordination.

The following recommendations are based on:
1. the focus group meetings held in June, 1996
2. the information gathered in the U.K.
3. the needs assessment

Recommendations:

These recommendations fall into two interconnected categories, one specific to the creation of a hospice in Kings County, the other regarding the co-ordination of already existing services.

Hospice:

1. The VON Kings Branch proceed immediately to conduct a feasibility study into the creation of a free-standing hospice.
   In conducting this study, it is recommended that the following be considered:

   A. The goals and objectives for the hospice;
   B. The physical layout and design;
   C. Types of services to be offered;
   D. Staffing (including the role of volunteers);
   E. How the hospice will fit into the existing continuum of services;
   F. The proposed catchment area;
   G. Funding, financing, legal and regulation issues;
   H. Appropriate management structures;
   I. Suitable purchase, rental, or leasing arrangements of property;
   J. Fund-raising strategies;
   K. Public education strategies.

General:

1. That services and programs for the dying and their important ones be more fully integrated and co-ordinated. That a central entry point for all programs and services for all palliative care clients be established while respecting the value of autonomy for some programs and services;

2. Provide more holistic health care with greater emphasis on psychological, social, spiritual, information and financial needs;

3. Provide preventative care not crisis orientated care;

4. Provide 24 hour care, 7 days a week;

5. Increase accessibility to formal caregivers, especially physicians;

6. Review the assessment procedures of the HomeCare Nova Scotia. Assessments of palliative clients must be flexible enough to allow for increase care as the need increases.

7. Increase accessibility to medical equipment, supplies and prescriptions;

8. Provide assistance to families or significant others with the transition phase from hospital and home;

9. Establish additional programs that provide ongoing support for caregivers and increase respite care for individuals who care for the dying in the home. Furthermore, provide follow up care for families or significant others after a lengthy illness of a loved one;

10. Provide further education programs and information in Kings County for professionals and the general public to raise the level of understanding concerning palliative care services and their underlying philosophy and principals. As well, increase education and information to caregivers in Kings County on pain and symptom control management;

11. Increase funding to existing programs and services for palliative care

Mind, Body, and Soul:
Exploring The Need For A Hospice In Kings County

Literature Review

Introduction

> There is an image of dying people that many Canadians have--the person is comatose, hooked up to monitors with intravenous tubing sticking out everywhere. We have too often seen our loved ones like this and we have seen them in pain and suffering.
>
> Hospice care is different. It makes sure that someone is relatively free of pain, is often able to be awake so they can remain an active part of their families until a few hours or days before death, does not use monitors or tubes, and tries to give as much control to the patient and family as they choose to have (Van Bommel 1992:24).

At a moment in history when technology in every discipline is expanding at an alarming rate, it is ironic that we are moving back towards our parents' and grandparents' gentler understanding of death--accepting it with a new understanding as an integral, dignified part of our life process and importantly, bringing the dying back into our homes and communities. The palliative/hospice movement has been a crucial component reflective of this change.

A central theme of palliative/hospice care is the belief that the terminally ill should be relieved of pain and that, whenever possible, the dying should have the dignity and support of home environment and family or significant others. The palliative care movement has been successful in bringing both of these messages and the techniques that support them to millions of individuals over a relatively short period of time. It is, perhaps, not surprising when we consider how deep a human chord is struck by such basic concepts.

The present generation of Canadians never learned to cope very well with death. Former generations did better because they grew up in a world that recognized dying as part of living. Perhaps they were closer, in what seems to have been a simpler time, to the natural order of life. What is certain is that, for them, it was common to lose friends or loved ones

by the age of puberty. Dying and grieving were part of community life--whether in city neighborhoods, small towns or rural farmlands. Mostly, people died at home where their families closed ranks in mutual support, helping both the dying and themselves to face the unknowable journey of life.

The purpose of this literature review is to expand our understanding of the power and importance of hospice care in Canada. On-line searches of a number of data bases were used to identify the literature. The main focus of the search was on Canadian literature, however, due to the lack of literature published on Canadian hospice care, international literature has been used in some instances to provide a global overview.

The Role of Palliative Care in Health Care

The role health care plays in treating and serving the needs of the chronically and terminally ill has been increasingly questioned from all sides (Abel, 1986; Gilbar & Steiner, 1996; Luchins & Hanrahan, 1993; Saunders, 1990). The high technology that epitomizes the modern health care system, combined with the medical education that emphasizes diagnosis, treatment and cure, is thought by some to become irrelevant and even alienating when cure is no longer a possibility. Numerous researchers have documented the psychological needs of the dying patient (Cassileth et al., 1985; Ross & MacDonald, 1994; Kastenbaum, 1995; and Zimmerman, 1981). The depersonalizing aspect of high-technology medicine has been said to ignore the needs and strengths of the *whole* person in pursuit of eradicating the disease. The bureaucratic process of health care may be counterproductive in meeting these needs and may even serve to distance the patient from their caregivers, friends, families and significant others. The patient may, therefore, experience *social* death before biological death (Kastenbaum, 1995).

Nonetheless, palliative treatment is a form of care, which is often debated and unfortunately, often misunderstood. The Jack Kevorkian's mercitron (suicide machine); and more recently and close to home, the highly publicized Nancy Morrison case in Nova Scotia, have made society question the methods of responding to and treating individuals with life threatening illnesses and chronic disease.

What Is Palliative/Hospice Care?

Hospice care and palliative care are like in definition. The term hospice, derived from the Latin term *hospitium*, lends the meaning 'to host'. The term palliative implies 'to relieve symptoms of a disease without curing' or 'to provide comfort care'. Throughout the United States and United Kingdom, the word hospice is used most often. In Canada, the French translation of the term *hospice* meaning 'dying in the poor house' resulted in the term palliative care being adopted in the mid 1970's (Von Bommel 1992:23). In terms of common usage the word 'palliative' in Canada often refers to a hospital program while the word 'hospice' often refers to the care provided in the community. For the purpose of this report the term 'palliative' refers to care for the dying and their loved ones in the hospital and community and the term 'hospice' refers to a facility for the dying and their loved ones.

Currently, there is no nationally accepted definition of palliative care. The Canadian Palliative Care Association's working definition of palliative care is:

> Palliative care, as philosophy of care, is the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with a life threatening illness. During periods of illness and bereavement, palliative care strives to meet physical, psychological, social and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs,

and practices. Palliative care may be combined with therapies aimed at reducing or curing the illness, or it may be the total focus of care.

Palliative care is planned and delivered through the collaborative efforts of an interdisciplinary team including the individual, family, caregivers and service providers. It should be available to the individual and his/her family at any time during the illness trajectory and bereavement.

While many service providers may be able to deliver some of the therapies that provide comfort and support, the services of a specialized palliative care program may be required as the degree of distress, discomfort and dysfunction increases.

Integral to effective palliative care is the provision of opportunity and support for the caregivers and service providers to work through their own emotions and grief related to the care they are providing (CPCA 1995:41).

Health Canada's definition of palliative care is:

Palliative care is a program of active compassionate care PRIMARILY directed towards improving the quality of life for the dying.

It is delivered by an interdisciplinary team that provides sensitive and skilled care to meet the physical, psycho-social and spiritual needs of both the patient and the family. The philosophy and principles of palliative care may apply to patient population other than the dying and palliative care programs may have a SECONDARY role in addressing the needs of these populations (Health Canada 1989:1).

The principals of palliative care in Canada have been outlined by the Canadian Palliative Care Association. They are:

1. ***Meet Physical, Psychological, Social and Spiritual Expectations/Needs***
   Care is directed towards meeting the physical, psychological, social, and spiritual expectations/needs of the patient and family with sensitivity to their personal, cultural and religious values, beliefs and practices.

2. ***Access***
   Patients and families have timely access to information and the services provided by palliative care when they need and are prepared to accept them.

   Information and services are provided in a language that they can understand.

   Essential palliative care services are available 24 hours a day, 7 days a week.

3. *Equal Availability without Discrimination*
Palliative care services are equally available to all regardless of their age, gender, national and ethnic origin, geographical locations, race, color, language, creed, religion, sexual orientation, diagnosis, disability, availability of a primary caregiver, ability to pay, criminal conviction, family status.

4. *Ethics*
The ethical principles of autonomy, beneficence, non-maleficent, justice, truth telling and confidentiality are integrated into the provision of care and program development.

5. *Right to Information*
It is the patient's right to be informed about his/her disease, potential treatments and outcomes, appropriate resources and options.

It is the family's, caregiver's and service provider's right to be informed about the disease, potential treatments and outcomes, appropriate resources and options, respecting the patient's right to confidentiality.

6. *Right to Choice/Empowerment*
Decisions are made by the patient and family in collaboration with the caregivers and service providers, respecting the level of participation desired by the patient and family.

The patient's and family's choices for care, setting of care and information sharing are respected.

7. *Unit of Care*
The unit of care is the patient and family.

8. *Interdisciplinary Team*
Care is provided by an interdisciplinary team of caregivers and service providers working collaboratively with the patient and family.

9. *Continuity of Care*
A co-ordinated, continuous plan of care, which minimizes duplication, is maintained across all settings of care from admission of the patient, to bereavement support of the family.

10. *Community Collaboration Through Partnerships and Mutual Support*
The palliative care needs of a community can only be met through the collaborative efforts of available services in partnership at patient care and programmatic levels.

11. *Governance and Administration*
Governance and administration are essential to support the program and ensure accountability. Broad based governance includes community representatives, caregivers, service providers, patients and families.

12. *Quality of Care*
Care is delivered by all service providers within professionally accepted standards of conduct and practice.

13. *Program Evaluation*
Program evaluation is essential to the delivery of quality palliative care and to the maintenance of standards of conduct and practice.

14. *Education, Information, Research and Advocacy for Palliative Care*
Education, information, research and advocacy for the development and maintenance of public policy, palliative care standards and resources are essential to improve the delivery of palliative care (CPCA 1995:43).

Who Is Usually A Recipient of Palliative Care?

According to the USA and UK demographics, historically, most palliative clients have been elderly persons suffering from cancer, however, this is changing. In general, palliative patients are nearly as likely to be male as female, with a small of percentage of females being greater than males. The large majority are white. Non-whites appear to be underrepresented in the use of palliative care. Across all studies the average age appears to be in the mid to upper 60's. It is clear that almost all palliative patients have had cancer as their primary diagnosis. Malignancies of the lung, colon, breast and prostate are most common. Other frequent diagnosis upon admission for palliative patients are diseases of the circulatory system with congestive heart failure; diseases of the respiratory system; diseases of the nervous system and sense organs, including Alzheimer's, Parkinson's, Meningitis, etc.; and infectious and parasitic diseases, which include Human Immunodeficiency Virus (HIV/AIDS). (Hospice Association of America, 1996: 9; Directory of Hospices and Palliative Care, St. Christopher's Hospice Information Services, 1997:3).

The length of hospice stay is a crucial indicator of the composition of patients admitted: it often correlates closely with the intensity of resources required on a daily basis. The length of stay for patients strongly relates to their functional status and nursing care needs at the time of admission (Mor & Hiris, 1985: 409). The average length of stay in the US and UK hospices is less than 22 days. This suggests that patients who are closer to death may have more severe conditions, which are likely to require inpatient care. In general, the median length of stay appears to be between 30 and 45 days, with an average ranging from 17.7 to 115 (Hospice Association of America, 1996: 7; Directory of Hospices and Palliative Care, St. Christopher's Hospice Information Services, 1997:3). However, it should be noted that the length of stay in a hospice program for children with a life threatening illness and individuals with HIV/AIDS vary because of the unpredictability of the disease trajectory. Some hospice client's stays are for the purpose of pain control and symptom management, these clients are sometimes discharged, to die at home or return at a later date.

With the advent of HIV/AIDS in Canada, some palliative programs and services are reorienting their polices to work with younger patients who do not view entering a hospice as a decision to give up hope or discontinue activities geared toward positive healing. In fact, some AIDS patients experience fluctuations in their health that allow for periods in which they do not require hospice care (Flannery et al., 1997:17).

Where Did Hospice Care Originate?

The term *hospice* stems back to medieval times when it was used to describe a place of shelter and rest for the weary and the sick travelers returning from religious pilgrimages, and later a place for wounded Crusaders to rest and receive treatment (Munley 1983: 28).

The modern hospice movement generally credits Dr. Cicely Saunders for instituting the founding philosophy of hospice care. She established St. Christopher's Hospice near London in 1967 where her program combined modern pain control techniques with the compassionate care for the dying (Munley 1983: 28). There were actually a few institutions in existence before St. Christopher's that offered palliative care to the dying. Dr. Saunders learned her techniques of pain control from St. Luke's Hospital in London where she worked as a volunteer after the Second World War. St. Luke's was founded in 1893 as a "Home for the Dying Poor" and cared for those dying with cancer and tuberculosis (Saunders 1990: 14). "The general attitude of the staff, the standard of nursing, and still more, the control of pain achieved by the regular giving of oral narcotics was impressively better than anything seen in teaching and general medicine" (Saunders 1990: 14).

With the assistance of Dr. Saunders the movement spread to North America in 1974 with the opening of the New Haven Hospice in Connecticut (Munley 1983: 28).

Palliative Care In Canada

Early palliative care movement in Canada tended to be institution-based. The first palliative care programs were established in Montreal and Winnipeg hospitals in 1975. The subsequent palliative care programs and services in Canada have historically originated at the grassroots level. These programs and services emerged from the unmet needs and wants of the community at hand. This development of local programs and services has led to an inconsistency in the services provided across Canada. The Canadian Palliative Association was established in 1991 in an effort to standardize palliative care in Canada. According to the 1997 Canadian Directory of Services: Palliative Care and HIV/AIDS, there are 594 palliative care programs in Canada. Located in both urban and rural settings throughout ten

provinces and two territories. these programs seek to provide a holistic response to the needs of each community with respect to the dealing with life threatening illnesses. Table 1 illustrates this break down.

Table 1

Province or Territory	Number of Palliative Care Programs
British Columbia/Yukon	75
Alberta	31
Saskatchewan	32
Manitoba	35
Ontario	303
Quebec	38
New Brunswick	11
Nova Scotia	48
Prince Edward Island/ Newfoundland	21
TOTAL	594

It should be noted that the directory information (CDSPCHIV/AIDS) is collected by a self-reporting questionnaire. While one might perceive that there are numerous accessible programs located throughout Canada. this is not always true. Some programs in a urban setting offer a wide variety of services while others in a rural setting might only provide one service.

Currently, although individual programs vary, there are at least six identifiable types of palliative care programs in Canada:

1. *Home care*. With home care, the patient may choose to remain in the home until death, being treated by visiting doctors, nurses, LPNs, home support workers, social workers, spiritual counselors, volunteers and other caregivers as needed or desired. People receiving care in the home may sometimes go to the hospital or clinics to receive with pain and symptom control.
2. ***Free-standing Hospices***. A facility separate from any other institution providing only palliative care (i.e., Canuck Place in British Columbia, Maison Michele Sarraizin in Quebec, and Casey House in Ontario). Patients are often referred by a family physician or specialist. These facilities do not have operating rooms, specialized life-support systems or the other features of a hospital.
3. ***Palliative Care Units in a Hospital.*** A separate unit within a hospital which provides palliative care. These units are often designed and decorated to give a more home-like atmosphere than other hospital units.
4. ***Palliative Care Team (consultation team) within a Hospital.*** Rather than having a separate unit within a hospital, many hospitals now have a multi-disciplinary team of doctors, nurses and other caregivers who provide care to patients regardless of where they are located in the hospital. The team educates the regular caregivers in pain and symptom control and encourages the emotional, spiritual and informational supports that individual patients need.
5. ***Extended Care Services.*** These are programs in institutions such as nursing homes and long term care facilities. These facilities may have a palliative care team and/or a special unit for patients who are dying.

6. *Regional Palliative Care Programs.* Some regions of Canada.. e.g. Victoria. BC and Ottawa-Carleton. Ontario have regionalized their palliative care programs to coordinate the services of hospital based and community based hospice programs (Van Bommel 1992:26-27).

Despite the many programs in Canada. Von Bommel (1992: 12) estimates that only 5% of individuals who are dying receive palliative care. Many patients with life threatening illnesses experience problems with pain and symptom management. notwithstanding the availability of effective medical and alternative therapies. Although medical therapies are available. accessing these therapies remains a problem.

Summary

The palliative care movement is bringing the dying back into our homes and communities. It is helping society view death as a natural part of the life process and not a social problem. Palliative care focuses on the relief of symptoms. pain control. and provision of support to patients and their loved ones. Palliative care programs in Canada play an important role in helping the dying and their significant others make choices which honor their personhood. There are different types of services offered to dying persons in Canada. Those services committed to palliative care are striving to educate the formal and informal caregivers in a holistice. dignified approach to death. In conclusion. I leave you with the dying person's Bill of Rights.

The Dying Person's Bill of Rights

1. *I have the right to be treated as a living human being until I die.*
2. *I have the right to maintain a sense of hopefulness however changing its focus may be.*
3. *I have the right to be cared for by those who will maintain a sense of hopefulness, however changing this might be.*
4. *I have the right to express my feelings and emotions about my approaching death in my own way.*
5. *I have the right to participate in decisions concerning my care.*
6. *I have the right to expect continuing medical and nursing attention even though 'cure' goals must be changed to 'comfort' goals.*
7. *I have the right to be free from pain.*
8. *I have the right to have my questions answered honestly.*
9. *I have the right not to be deceived.*
10. *I have the right to have help from and for my family in accepting my death.*
11. *I have the right to die in peace and dignity.*
12. *I have the right to retain my individuality and not to be judged for my decisions, which may be contrary to the beliefs of others.*
13. *I have the right to discuss and enlarge my religious and/or spiritual experiences whatever these may mean to others.*
14. *I have the right to expect that the sanctity of the human body will be respected after death.*
15. *I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death*

(Hospice Society of Victoria County 1994:105).

Mind, Body, and Soul:
Exploring The Need For A Hospice In Kings County

Focus Group Meeting

Focus Group Meeting

A focus group meeting was held on June 21st at the Eastern Kings Memorial Health Centre Clinic in Wolfville, with a variety of health care providers unanimously agreeing that each of the services represented had sufficient clients who could benefit from a hospice, thus warranting the need for further research.

A total of 16 individuals participated in the focus group. Present at the meeting mentioned above were representatives from the VON (2 nurses, the Coordinator of palliative care volunteers and the Coordinator of volunteer services), the health promotion nurse at Eastern Kings Memorial Health Centre, the Director of the Kings County Home Support Agency, 4 palliative care volunteers, the Coordinator of the Valley AIDS Concern Group, 4 Home Care Nova Scotia Care Coordinators, the palliative care nurse from Valley Regional Hospital and a researcher from Acadia University.

Uses for the proposed hospice which these care providers identified include the following: a facility for short term respite care, a resource centre for pain and symptom control, a place for younger adults to go when they did not want to cause their young children and/or their partners additional stress, a place to provide caregiver (professional and others) counseling and resources, and a setting in which day care could be provided for dying persons whose caregivers need respite. It was pointed out by many present that continuity of care would be an extremely valuable feature of the hospice experience and one which would enable a flexibility of funding and services.

All present at this focus group meeting were extremely supportive of and excited by the concept of a community-based hospice. All agreed to participate in further discussions of this project and to assist with the needs assessment.

Mind, Body, and Soul:
Exploring The Need For A Hospice In Kings County

Hospice Care in the United Kingdom

Hospice Care in the United Kingdom

Introduction:

During the months of January through June of 1997 I visited free standing (not attached to hospitals), small (not more than ten bed) hospices in the UK. This research was part of a six month sabbatical from Acadia University where I teach courses in the Sociology of Death and Dying, among others.

I undertook this work in collaboration with the Victorian Order of Nurses, Kings County Branch as we wished to explore the need for a hospice in Kings County. As the hospice movement began in the Britain it seemed worthwhile to see what we could learn from their experiences over the past forty odd years.

I visited a total of twenty-five, ten bed and under facilities (I also visited St. Christopher's, St. Joseph's, a Marie Curie Centre, a Sue Ryder home and several other more than 10 bedded hospices), scattered across England. In addition, I visited a hospice in Wales and one in Scotland. What follows is a brief overview of what I learned from these visits.

The UK Hospice Scene:

Hospice services are broken down as follows:

Inpatient Units	**Units**	**Beds**
Voluntary hospice units	148	2218
Marie Curie Centres	11	289
Sue Ryder Homes	8	151
National Health Service Managed units	56	3253 (St. Christopher's Hospice Information service)

Hospice or Palliative care is provided in the form of Inpatient Care, Care at Home, Day Hospice and Hospital Support Services. There are a small number of hospices which provide care especially to those with AIDS/HIV and an ever increasing number (25 presently) which provide services only to children. There is also a hospice specifically dedicated to the care of infants 6 months and younger.

There are 5 main agencies responsible for providing **Inpatient** hospice/palliative care in the UK. They are:

Voluntary (independent) hospices, usually set up as registered charities, funded in part by the National Health Service and local community funds. Approximately 75% of inpatient care is provided by voluntary hospices.

NHS Palliative Care Units or Centers managed and funded by the NHS specifically for palliative care. Usually located within a hospital setting. Sometimes as part of a teaching hospital affiliated with a University.

MacMillan Cancer Care Units funded and built by the charity, Cancer MacMillan Relief, most units are in hospital settings funded by the NHS. There are also other units operated by the voluntary sector.

Marie Curie Cancer care run 11 'centers' (preferring this term to 'hospice' because those who provide charitable donations are uncomfortable with the concept of a hospice as a place to die) across the UK ranging in size from 10 to 44 beds. These centers care predominantly for patients of all ages with cancer.

Sue Ryder Homes provide inpatient care predominantly for persons with a wide range of disabilities including 8 homes specifically for patients with advanced cancer.

Care at home is provided to approximately 50% of patients with advanced cancer or other terminal illnesses, according to those I spoke with at both the Hospice Information Center at St. Christopher's Hospice and the National Council for Hospice and Specialist Palliative Care Services. Such care is provided by district nurses and MacMillan specialist nurses (who is often *the* local consultant on palliative care/hospice matters) in consultation with local GP's and hospital consultants. Care at home may also be provided by a voluntary hospice, community NHS Trusts or Marie Cure Cancer Care.

Several teams provide an extended nursing service known as "Respite Care at Home" or "Hospice at Home" enabling patients to stay at home longer and to avoid admission to a unit or hospice. Care at home can also be supported by experienced volunteers usually referred to as "befrienders".

Care at home usually involves a careful assessment and management of symptom and pain control, night sitting services, the provision of emotional support to the dying person and her or his important ones, and respite care.

Voluntary Hospices provide approximately 40% of the home care nursing services, Community NHS Trusts provide the remaining care most frequently utilizing the services of MacMillan Nurses. According to MacMillan nurse specialists I interviewed, there are at present over 1,400 Macmillan nurses working in hospitals, hospices and palliative care services and in the community as part of the NHS.

Marie Curie Cancer Care has over 6,000 nurses throughout the UK who provide hands-on, round the clock nursing care to cancer patients in their own homes at no cost to the patient.

Day Hospices:
An interesting development in the UK death care system is the Day hospice and one which impressed me greatly in terms of its ability to assist patients and their families in providing a full day respite situation for the caregiver, as well as the opportunity to learn new skills, enjoy a wide range of alternate therapies aimed at enhancing comfort and self esteem for the patient, who could also benefit from the opportunity to socialize with others, particularly at lunch , to participate in a wide range of leisure activities from pottery making to ceramics, art, play writing, learning computer skills, attending field trips and so on.

Each of the hospices I visited had transportation available for day care patients. Some had their own buses while others utilized volunteer cars and drivers. This provided the caregiver with a full day of respite without having to transport their important one to and from the daycare. There were a wide variety of complimentary therapies available for patients in day care such as aromatherapy, physiotherapy, light therapy, massage therapy, occupational therapy and reflexology to name but a few. These services were usually performed by registered professionals who provided their time and expertise in a voluntary capacity. Also available in some day hospices were hairdressing, chiropody, beauty treatments, small but well stocked libraries, pottery wheels and kilns, photography dark rooms and other facilities aimed at enhancing already existing interests or sparking new ones.

Hospital Support Services provide symptom control, pain relief and emotional support for patients and carers. Some hospitals have a palliative care team consisting of doctors, nurses, social workers, chaplains, while others have support provided by a single MacMillan support nurse.

According to St. Christopher's Hospice Information service the present breakdown of Hospice and Palliative Care Services is as follows:

Home Care Teams (including MacMillan Nurses)	408
Day Care Centers	234
Home Respite Services	60
Hospital Support Nurses	176
Hospital Support Teams	139

(Interview with Ann Eve, Information Officer, February 6,1997)

All hospice/palliative care services in the UK are free to patients and their important ones.

Referral to a hospice is usually made by a GP, but patients can self refer (in consultation with their GP) or important ones can refer. As well, hospital consultants, MacMillan nurses and Marie Curie nurses can refer patients.

The number of beds within each hospice varies from 2 - 63 beds with the larger units being the older ones (built twenty or more years ago) or located within hospitals. The smaller units are more likely to be purpose built with approximately 10-12 beds.

Similarities and Differences In The Hospices I Visited:
(The themes used here are taken from responses to a questionnaire which was completed at the time of my visits).

How Long in operation?
Most of the hospices had been in operation from 2-10years, these were essentially purpose built or converted houses. Older hospices has been in operation from 11-37 years. Some hospices began with bereavement services, then day care, in-home care and finally in-patient beds. Others began with in-patient beds, then added day care and in-home care which included bereavement services. Those which provide consulting services to local hospitals have been doing so for the past 3 years.

How many people serviced?
Depending on what types of programs were provided, hospices could service from 100-400 patients on a regular monthly basis. Those which offered in-patient beds, day care, in-home care, bereavement services, hospital liaison and consultants and who had MacMillan nurses working in the community provided more services to more clients. The children's hospice could provide service to 6-8 patients and their important ones, the baby hospice limited itself to 6 infants at a time.

How many beds?
The numbers of beds ranged from 6-10 with the majority having ten. The baby hospice had six cots with additional family rooms, the children's hospice had 7 beds. Some hospices began with less beds and added more as needed. Most hospices had facilities to accommodate important ones for overnight stays. Some hospices reserved one or two beds specifically for respite care. One hospice had family rooms where patients could stay with their important ones.

Average stay?
The average length of stay in the hospices was two weeks. Most hospices had a 50% discharge rate and patients left to die at home or their symptoms had improved sufficiently to allow them to return home. Most hospices had waiting lists with priority given to those in most need.

Catchment Area?
All hospices had specific catchment areas which were designated by regional health authorities under the NHS. Some made exceptions where they felt that the individual could not be effectively treated unless they entered hospice and if beds were available. Populations covered by the catchment areas ranged from 140,000 persons to 1.4 million. In some areas there was more than one hospice or palliative care service.

In some cases hospices would accept patients who did not live in the catchment area if they had relatives who did.

Admission criteria?
A terminal diagnosis was the most common criteria as well as advanced cancer, symptom control (especially complicated symptoms) and respite care needs. Some hospices were more flexible than others about their admission criteria. Some admitted that they had no rigid criteria but instead looked at each case in isolation and in terms of whether they felt they could offer patients what they needed.

Referral process?
Most hospices had flexible referral processes whereby a patients could apply her/himself or could be referred by important ones. However, in all cases the local GP had to agree to a patient being placed in a hospice. In some cases hospital consultants or MacMillan nurses would also refer in consultation with GP's.

Types of services offered?
All hospices provided, and saw as essential to the hospice philosophy, pain control and symptom management. All except one provided day care. All provided in-patient beds and bereavement services either on a one-to-one basis or via groups. All provided respite services and complimentary therapies, aromatherapy being the most common. The majority provided in-home services but some did not. All in-patient and in-home services were provided 24 hours a day, 7 days a week. Other services provided by some hospices included: Physiotherapy, occupational therapy, help line (operated by volunteers over the telephone), lymphodema services, consultants, educational and training services and MacMillan nurse consultants to local hospitals and GP's (sometimes referred to as the hospital link scheme), and a range of leisure activities generally provided by qualified volunteers. All hospices provided free transportation to day care, either through the use of their own bus, or with the help of volunteer drivers. Services aimed at enhancing self esteem were also provide by some hospices including beauty shops, hairdressing, bathing facilities for day care patients, foot care, counseling etc.

All hospices had Hi Tech automated bathing units which could be lowered or made higher for patient comfort and ease of eye contact between patients and those assisting them to bathe. Most had electric showers which were adjustable to a patients height and were surrounded by wall rails for support. Most hospices had special lifting devices to assist staff help patients to have baths or move while in bed.

Some had special moving equipment which could take a patient from a bed and place her or him in the bath. Many noted that being able to have baths while at day care was a great incentive to encourage patients to attend because many could not bathe at home.

Types of professionals?
Most hospices had paid medical directors who were doctors specialized in palliative medicine, one had a retired GP as a voluntary medical director. Some wanted to have medical directors but there was a shortage of such persons in the UK. Some were led by a MacMillan trained nurse with local GP's providing their services as volunteers on a one day a week each system.

There was a great deal of dispute amongst some of the people working in the hospices as to whether or not a medical director was needed and whether or not hospices should be physician or nurse driven. In the academic palliative care setting, in hospitals attached to universities and colleges, there is a trend suggesting that all palliative care facilities hire physicians with a specialist option in palliative care. This requirement was not seen as essential in most of the hospices I visited and it seemed a case of the 'us and them' scenario with academics in the field being out of touch with the grass roots hospice providers.

All hospices had a full range of nursing staff although there is presently an acute nursing shortage in the UK and some hospices were understaffed in this area. The average patient/nurse ratio was 1 to 1, although some were as high as 1.4 nurses per patient. All hospices had a range of paid, administrative staff on a full time or part-time basis. Most had full time, paid fund raisers and volunteer coordinators.

Some had paid full-time MacMillan nurse specialists, others shared these nurses with the local health authority who either paid their salaries in full or part. In most cases the MacMillan Cancer Relief Fund provides nurses to a health authority for a three year period at their expense, after that time, the health authority or hospice is required to pick up the salary.

Most hospices had a full range of complimentary therapies usually supplied on a voluntary basis by registered therapists. Very few had full-time social workers but utilized those available via the local health authority, this was usually the case as well with occupational, speech and vision and physiotherapists. All had chaplains or spiritual advisors who provided these services as volunteers Most hospices had either a paid administrator, or volunteer who performed these tasks, or a management team which usually consisted of the medical director, matron, administrator or manager and fund raiser/financial director.

When asked on what basis (either paid or voluntary) these professionals were involved in service delivery the responses varied depending on what was offered and on what basis. Some hospices had more paid staff than others and it seemed to depend on the philosophy and obviously budget considerations of those I talked with as well as the expertise available within any given area.

On-going education for staff?
All hospice contacts said that they provided regular on-going education to their staff, especially nurses. Most educational programs were in-house but some hospices did have educational allowances to enable each staff member to receive education elsewhere. Some hospices provided educational programs for others in their communities including local hospital staff , GP's and district nurses. Two hospices provided placement positions to local nursing colleges. Topics could be generated by anyone in the hospice based on their need for education and information. Some hospices had regularly scheduled educational events, others based more on need.

Number of volunteers?
The number of volunteers utilized by each hospice ranged from 100-300 depending on the types of services provided. The baby hospice had no volunteers and was run strictly by paid personnel. Some hospices made extensive use of their volunteers in the laundry, kitchen, garden, reception, administration, fund raising, building maintenance/repair areas. Others utilized volunteers exclusively in day care or as drivers. Some hospices made use of volunteers in at-home services as visitors (befrienders) and in bereavement care. Most complimentary therapies and self-improvement services were provided on a voluntary basis but volunteers were required to be registered members of their specific professions. Some hospices provided small transportation allowances to their volunteers.

Recruitment of volunteers?
The majority of hospices recruited volunteers by word or mouth, through local advertising, at local churches and schools, fire stations and rotary clubs, various women's and men's groups and through local volunteer bureau's. Posters were placed in doctors offices as well. Many hospices are heavily involved in public relations activities giving talks at local hospitals, libraries and community centers and recruit new volunteers in this way too. For specific events such as garden fete's, open houses, Easter parades, Christmas plays etc., volunteers are recruited via the local print, audio and visual media.

Age ranges and gender of volunteers?
Generally the ages of volunteers ranged from 16-90 although one hospice would not accept volunteers younger than 18 years of age. The average ages of volunteers was between 45-55. The majority of volunteers were women, usually 90-95%.

Volunteers were not required to have specific skills or experiences other than those who worked in the complimentary therapies or self-improvement areas as noted earlier. If specific skills were required for special projects then recruitment activities were engaged in to meet these unique requirements.

Most hospices did not have trouble attracting volunteers but others, most notably those in urban areas, did. In part this seemed to be because the traditional volunteer female aged 55 and over with children now gone, is no longer volunteering either because she wants to work, or needs to. Many London based hospices are faced with recruitment challenges and groups previously underutilized as volunteers, namely young people, males, disabled individuals and persons of color are now actively being pursued by some hospices. All hospices reported a problem of attracting ethnic minority volunteers. Most hospices were seriously reconsidering the use of volunteers in certain areas of care and were actively creating ideologies and philosophies about how to enhance the volunteer experience in ways which more fully recognize volunteers' needs and reasons for volunteering. In general there was recognition that volunteers needs to learn new skills or enhance old, perhaps outdated ones, that they need to feel valued and important to the hospice and that where possible they should be reimbursed for out of pocket expenses related to their voluntary role.

Most hospices provided regular training to their volunteers but it depended on where they worked. The areas where on-going education was seen as most important was in day care, in-home care, bereavement follow-up and transportation. Most hospices provided an initial induction program for new volunteers, usually 6-8 days in length (spread out over a varying number of weeks or months) covering the basics of hospice/palliative care. In some hospices more in-depth programs were offered which dealt with issues such as multicultural needs, spiritual needs, working with people with specific diseases (most notably AIDS/HIV), etc. Some hospices provided volunteers with funding to attend local workshops and conferences on hospice/palliative care and related topics.

Primary causes of death?
The primary causes of death of those utilizing hospice services were Cancer, Motor Neuron Disease (in Canada ALS), AIDS/HIV, Duchenne Muscular Dystrophy, and Cardiac Failure.

Funding?
The majority of hospices were funded on a 30% (NHS) to 70% (donations) scale. A few were funded by the NHS for up to 40%. Annual budgets were in the 750,000 to 1.4 million pound range depending upon number of beds, location and land prices, types of staffing, type of facility i.e. purpose built or renovated, already existing housing, types of services offered etc. In a few cases land was donated for the building of or adding onto an already existing structure. This was especially the case with add on day care centers in older hospices.

All hospices had paid fund raisers, some had more than one such position. All but two had charity shops which sell used clothing, books and other household items. These charity shops are all run by volunteers and all goods sold are donated. All hospices had paid volunteer training coordinators.

In many hospices patients make crafts during day care activities and these are sold either in the hospice, through charity shops or through local stores in the community. On occasion a patient who is no longer able to work will donate their skills to the local community and give the money earned for their tasks to the hospice. I met a carpenter with motor neuron disease who provided his expertise to local consumers and gave his salary to the hospice, also a computer programmer who did likewise.

Fund raising activities ranged from lotteries, change boxes which were placed in each individuals home (and provided an unexpectedly large amount of funds), donate as you earn, direct payments on a monthly basis, specific fund-raising drives for hydra-therapy pools, aromatherapy rooms, various art supplies etc. One hospice had asked the local bus company to donate the salary for a MacMillan nurse specialist and they agreed and have paid this salary for the past five years. There are also special cancer lotteries and daffodil days similar to those in Canada.

If hospices did receive charitable donations from the corporate sector it was usually in the form of equipment, special rooms or activities. Many hospices utilized the assistance of Help The Hospices, a national charity, to help them provide staff and volunteer training.

Networking?
All hospices engaged in networking activities with other institutions and organizations, especially professional bodies for doctors, nurses and administrators, health authority boards and national hospice associations.

Relationship to National Health Service?
Most hospices had limited relationships to the NHS other than through their local health authority. Most saw themselves as independent of government and responsible primarily to their communities and clients.

How close is nearest hospital?
Most hospices were within 1-5 miles of the nearest hospital. Most utilized the blood testing, X-ray and CT scan facilities of the local hospitals. Some hospices did have their own blood collection services as there are courier systems throughout the UK which pick up blood on a once or twice a day basis.

The involvement of important ones?
All hospices noted that important ones could be as much involved in patient care as they and the patient wished. In some cases where immigrant patients were at the hospices, especially those of Sikh origin, family members provided much of the daily hands-on care, which often included meal preparation and personal care and hygiene. Important ones were encouraged to feel as welcome as possible in all aspects of patient care. In general though it was felt that family members and other significant persons were pleased to allow hospice staff to conduct the majority of care.

Bereavement care?
All hospices provided bereavement care in one form or another. Most did not have strict guidelines about how long such care could be provided after death, others had a one year maximum. Bereavement care was provided either by social workers or volunteers although it must be stressed that all hospices saw bereavement care as an important and natural component of quality palliative care. In this sense bereavement issues were discussed with patients and loved ones throughout their hospice experience.

Some hospices acknowledged a death by burning a candle for 24 hours as a reminder to all in the hospice that a loss had taken place. This candle was usually placed on the counter in the nurses area. Most hospices had an anniversary scheme where cards were sent to important ones recognizing their loss. Some hospices had memorial books which listed the names of all who had died within them, including staff and volunteers.

Some hospices provided telephone support services to the newly bereaved, some one-to-one counseling, others group or a combination of both. Most hospices visited included bereavement services for staff, usually at a regular weekly or day meeting when patients would be discussed and remembered.

Involvement of local community?
The most common responses to this question was "the hospice is theirs" or "we wouldn't exist without them". Specifically the community provided volunteer support, funds, remembrance services, hospice recognition days, goods and services, support and encouragement and neighborhood visit days.

Is public education provided?
Understandably, due to their need for charitable contributions, all hospices strive to maintain a high profile in the local and national communities. Most had royalty on their boards of directors or famous actors and sports figures. Some were built because of the death of a local person, usually a younger one, and this raised a high profile in the media. Most hospices provided public education about their services to schools, churches and synagogues, local service clubs and organizations, rotary clubs and legions, housing groups, doctors groups, local hospitals and voluntary agencies. Many made arrangements with local media sources to have stories written about their activities on a regular basis. All hospices were aware of local events in which they might participate such as having floats at fairs, tables and literature at fete's and carnivals, having notice boards up in shopping malls and markets and generally being aware of being in the right place at the right time.

Physical layout?

Many, but not all purpose built hospices utilized the MacMillan Green Plan for architectural design. The main feature of this model is a central courtyard with flowers, trees and shrubs and sometimes a water fountain and pond. All patient rooms have access to this center courtyard and some have enclosures where beds can be wheeled out onto verandah's where patients may sleep if they wish. Some hospices which utilized this design also had common areas on the other side of patient rooms, with refreshment making facilities, books and magazines and televisions so that when patients left their rooms they could, if they chose, engage in social activities with others who either lived or were visiting the hospice.

Other hospices which did not use the MacMillan plan did utilize similar design features. Many hospices were designed in a sort of horseshoe shape to discourage the use of long corridors and to create the idea of a central meeting place. Most purpose built hospices had two single bedded rooms and two with four beds, most of these were same-sex based. A few had all single bedded rooms. All rooms had en suite bathrooms. All had large communal areas, kitchens for patient/family use, storage areas for wheelchairs and other equipment, medical sluice rooms and medication areas.

The usual layout included main entrance and reception area, patient rooms and day care on the first floor, with administrative offices, sometimes education and conference facilities on the second. Hospices which were located in renovated houses usually had more cramped quarters for staff.

Many hospice reception areas had items for sale made in the day care during craft workshops, also on sale were greeting cards with the hospice logos. A variety of brochures describing the hospice and its fund raising efforts were also available in the reception area. Some also had candy and soft drinks for sale for visitors.

Purpose built hospices included dining rooms for staff, some a separate area for the medical director and matron. Most included libraries and resource areas for everyone's use. Many hospices had literature about specific diseases and treatment available in these resource areas for staff, patients and others.

Day care facilities in both purpose built and renovated houses included a kitchen, for use by patients and staff, a dining room with cocktail areas for before lunch drinks (alcohol is served to patients who wish to consume it, in moderation, in all UK hospices and hospitals) , recreation rooms, bathrooms with either electric showers or special baths (as previously noted), toilets including assisted ones, quiet areas for personal reflection or a nap, access to gardens and greenhouses where available and sitting rooms. In most day care facilities there were a wide variety of board games, cards, puzzles and other items. Day cares also had televisions and in some cases CD players and computers.

All purpose built hospices had mortuary rooms where patients were taken after death so that families could be with them as long as they wanted. These rooms led into a mortuary area where the deceased could eventually be collected by an undertaker. Most mortuary rooms included refrigerators for overnight storage. One hospice included a private, enclosed garden within its mortuary suite. Another hospice had a special 'cold' bed so that when an individual died she/he could remain in their room with loved ones overnight and not have to be moved into the mortuary area. The rest of the room would be kept at regular/normal temperatures.

Most hospices had on-site laundry facilities. Kitchens for patient meals were usually on the first floor, sometimes in the basement, where there was one. One purpose built hospice had a separate kosher kitchen as well as a Moslem one.

Most hospices, but not all, provided smoking rooms for their patients, some even had them for staff.

Most hospices, especially purpose built ones were spacious, light and airy. Flowers (donated by undertakers from recently held funerals) were everywhere. Plants filled every room. One hospice provided fresh flowers with every meal tray. Two hospices had pets, in each case two live-in cats who had full range of the entire hospice but who usually chose to stay in the patient areas and spend their nights on patient beds! Each hospice had cat doors to allow the felines easy access to the outdoors.

Lack of storage space and lack of adequate areas for staff were commonly addressed problems in some hospices, the latter was especially the case in renovated houses.

All hospices had either a chapel, a spirituality room or a quiet room for prayer or reflection. Even though all hospices proclaimed that there were non-denominational and multi-faith, most still had crucifixes as the main focal point in each 'chapel', some had alters and various other Christian motifs such as bibles and statues. One hospice did have a very colorful wall chart which listed the dates, times and reasons for religious ceremonies of all faiths.

Some hospices had a library/resource room/study center primarily for staff use. A few hospices had play areas with games and toys for visiting children.

Tea/coffee and other snacks were available to patients who wished them throughout the day.

One hospice had 4 bedded patient rooms large enough to place additional beds in case important ones wanted to sleep with a patient (each bed was surrounded by screens when necessary). This hospice also had a large open area with comfortable armchairs and couches in the rooms and a dining sized table if patients wanted to, and were able to eat meals together or have important ones join them at mealtimes.

Important ones were able to make meals in most hospices if they wanted to, but these kitchen were only for snacks or micro-waved foods.

Most of the newer hospices, less than 5 years old, were purpose built. Others were either converted houses; one for in-patient hospice beds and staff, and another, usually next door and accessible via pretty footpaths, was used for day care. Older buildings where additional space or land was available were added onto as necessary.

Program evaluation?
There was surprisingly little program evaluation other than that required by the NHS under the Nursing Homes Act legislation in most hospices. The NHS requires that all nursing homes be audited twice yearly, one a scheduled visit, the other a surprise call.

Some hospices conducted internal audits on a twice yearly basis. One particular hospice had a very thorough system for evaluating every aspect of care. This program was initiated by one of the nurses as a result of her concern that care could be better provided in some areas of the hospice. Her suggestions for an internal audit was well received by her colleagues and she then proceeded to create a variety of assessment tools for every area of the hospice.

Multidisciplinary team?
Every hospice I visited said that it utilized the multidisciplinary team approach. The main advantages of this approach were said to include the benefits of sharing expertise at all levels, learning new ways to deal with patient care, working in a less stressful and competitive environment and having peer support.

The disadvantages of this approach were said to include hierarchical tensions, lack of effective communication between members of the team, too many faces for the patients to deal with, lack of or disagreement about focus and direction and lack of personal autonomy.

Vision of the future?
Most hospices saw themselves doing more of the same but more efficiently in terms of costs and care. Some wanted to expand their services by offering additional day care days, a few wanted to open a children's hospice. Many expressed the need to work more closely with the local hospitals and GP's and to provide more educational opportunities to their medical colleagues in their communities.

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Hospices Visited in the UK, January-June 1997

	St Luke's	North London	Lions	St Frances	Fair Haven	Luton & Beds	Highland	St John's
Budget	736,000 (pounds)	750,000 (pounds)	750,000 (pounds)	750,000 (pounds)	1,000,000 (pounds)	1,000,000 (pounds)	1,000,000 (pounds)	1,000,000 (pounds)
% NHS	31 9	20	7	35	30	30	32	4
Population	289,000	750,000	220,000	220,000	315,000	1,000,000	200,000	500,000
# of Beds	8	20	12	8	8	10	10	10
Day Care	•	•	•	•	•	•	•	•
Home Care	•	•	•	•	•	•	•	•
Respite Care	•	•	•	-	•	•	•	•
Bereavement Care	•	•	•	•	•	•	•	•
Care Givers Support	•	•	•	-	•	•	•	•
Nurses	•	•	•	•	•	•	•	•
Physicians	•	•	•	•	•	•	•	•
Volunteers	•	•	•	N/A	•	•	•	•
Medical Director	•	•	•	-	•	•	•	•
Physiotherapy	•	•	•	•	•	•	•	•
Social Worker	•	•	•	•	•	•	•	•
Chaplain	•	•	•	•	•	•	•	•
Complementary Therapies	•	-	•	-	•	•	•	•
Education Services	•	-	-	•	-	•	•	•
Library	•	-	-	-	-	•	•	•
Gardens	•	•	•	-	•	•	-	•

Legend *Service Available -Service Not Available ?Inf Not Provided ◦Fully Funded N/A Not Available

Hospices Visited in the UK, January-June 1997

	Dorothy House	Oakhaven	Ellenor	Edenhall	St Christopher's	Helen	Katherine
Budget	1.3 million (pounds)	560,000 (pounds)	?	?	?	?	700,000 (pounds)
% NHS	38	40	20	25	38	-	38
Population	440,000	150,000	300,000	?	1.5 million	?	180,000
# of Beds	14	8	7	32	62	6-8	10
Day Care	•	•	-	•	•	-	•
Home Care	•	•	•	-	•	-	-
Respite Care	•	•	•	•	-	•	-
Bereavement Care	•	•	•	•	•	•	•
Care Givers Support	•	•	•	-	-	-	-
Nurses	•	•	•	•	•	•	•
Physicians	•	•	•	•	•	•	•
Volunteers	•	•	•	•	•	•	•
Medical Director	•	•	•	•	•	-	•
Physiotherapy	•	•	-	•	•	-	•
Social Worker	•	•	•	•	•	-	-
Chaplain	•	•	•	•	•	•	•
Complementary Therapies	•	•	-	•	-	-	•
Education Services	•	-	•	•	•	•	•
Library	•	-	?	•	-	-	-
Gardens	•	•	?	•	?	•	•

Legend •Service Available -Service Not Available ?Inf Not Provided ◦Fully Funded N/A Not Available

Mind, Body, and Soul:
Exploring The Need For A Hospice In Kings County

Needs Asessment

Introduction

Every community has been and will be faced with the challenge of caring for individuals facing terminal illnesses as life expectancy and chronic disease increase and with the continuing spread of serious viruses such as HIV/AIDS. It is the responsibility of every community to review its resources and prepare for an increase in the number of individuals faced with life threatening ailments. Without such preparation, dying persons will have limited options, informal caregiver stress will become a greater concern, and hospitals and long term care facilities may become overcrowded. Moreover, home care and palliative care programs may be inappropriately utilized, care may be crises-oriented, and, in the absence of more appropriate options, the most expensive form of care may be used to address palliative care needs.

Objectives Of Needs Assessment

The objectives of this needs assessment are as follows:

1. To identify the unmet needs of individuals faced with a life threatening illness, their significant others, formal/informal care providers; and
2. To determine the need for a free-standing hospice facility in Kings County.

Statement of Need

The possible need for a hospice became evident to individuals volunteering and working with palliative care clients in Kings County, as they recognized that certain people in the community did not have the support necessary to die at home in comfort. Home Care Nova Scotia's mandate does not provide for 24 hour home care. Alas, persons in Kings County who choose to die at home need to have family or significant others who are able to care for them and who can be supported and/or relieved by the formal caregivers provided through HCNS. The alternative for those with minimal home support and care is hospitalization. This option has been the choice of many; however, it is of great expense, and for some, hospitalization would not be the preferred choice should other options be available.

An informal review of the clients serviced by VON, Kings Branch from January, 1996, to September, 1996, indicates that up to six clients per month may have chosen to use the services of a hospice in the long term (six weeks for more) and another six clients per month may have used the hospice to provide respite care for up to a week at a time.

In June of 1996, a focus group was conducted with interested health care providers and concerned community members to discuss the need for a hospice. It was unanimously agreed that each of the services represented had sufficient clientele who could benefit from a hospice to warrant further study. All present at the focus group were extremely supportive of and excited by exploring the need for a community based hospice.

As a result of the stated concerns of clients, staff and volunteers, VON Kings Branch sought funding to explore ways of providing individuals with the option of dying in a 'home-like' atmosphere. This exploration, in the form of a needs assessment was conducted between April and August of 1997 in Kings County, Nova Scotia. Under the direction of a 15

member *Palliative Care Advisory Committee*, data was collected from palliative care clients and personnel involved in the existing programs and services in Kings County *(see Appendix 1)*.

Kings County Demographics

The Kings County region of Nova Scotia is famous for its fertile soil and fruit orchards. The county is located between North and South mountain ranges separated by a wide valley floor. Kings County is characterized mainly as a rural farming area which entertains a strong and viable business district. The land area of Kings County covers 2,182. 24 Sq. kilometers. The population of the entire Kings County, including its villages and towns represents 56, 240 (Kings Community Economic Development Agency 1997:106).

Palliative Care Services and Programs In Kings County

There are various services, programs, supplies and equipment that are required for the care of palliative clients and their significant others. The following represents an inventory of services, programs, supplies and equipment that might be helpful to palliative clients and their significant others. The care provided by physicians is not indicated here.

In patient health care facility
Pain and symptom control
Emergency care
Help line (24 hours a day)
Nursing service
Dietitian

Swallowing disorders therapy
Enteral feeding
Enterostomal therapy -ostomy teaching, problem solving
Physiotherapy
Occupational therapy
Speech - language therapy
Oxygen and respiratory home care
Counseling
Alternative therapies -acupuncture, massage, aromatherapy, etc.
Foot care
Blood collection
Specimen collection
Medical equipment rental
Medical equipment loan
Supplementary foods
Meals
Special medical supplies, pads, dressing, etc.
Breast prosthesis
Vascular compression garments, extremity pumps and accessories, socks, turbans, etc.
Information/educational resources
Special Workshops -coping with chemotherapy and radiation side effect, or wound and skin care
Home support service -light house keeping, personal care, meal preparation
Respite care
Support groups -Living With Cancer, Reach For Recovery, Valley AIDS Concern Group
Supportive one-on-one visiting--volunteers
Bereavement support
Transportation -volunteer
Financial assistance

The above listed is provided in part by the service agencies, associations, and businesses listed below:

Berwick Physiotherapy Clinic
Canadian Cancer Society
Canadian Red Cross Society
Careforce Homecare Services
Community Services, Wolfville

Evangeline Nursing Home Care Nursing Services
Eastern Kings Memorial Health Centre
Home Care Nova Scotia
Kings County Social Services
Kings Physiotherapy Clinic
Kings Rehabilitation Centre
Life Line Oxygen & Medical Supplies
Mid-Valley Palliative Care
P.E.P Program (VON Volunteer Services)
Pharmacies across the county
Royal Canadian Legion
Senior Citizens Secretariat
Valley AIDS Concern Group
Valley Physiotherapy Clinic
Valley Regional Hospital
Veterans Independence Program
VON, Kings Branch
Western Kings Memorial Health Centre

Cancer Occurrences In Canada and Nova Scotia

The National Cancer Institute of Canada maintains that cancer is primarily a disease of the elderly. Estimates for 1997 indicate that 59,600 (45%) of new cases and 34,500 (56%) of cancer deaths occur in Canadians aged 70 years and up. An additional 34,300 new cases (26%) and 14,700 deaths (24%) occur in those aged 60-69. By contrast, only 1% of new cases and 0.3% of deaths occur prior to the age of 20 years (National Cancer Institute of Canada 1997:41).

In the province of Nova Scotia, it is estimated that there will be 5,200 new cases of cancer and 2,400 deaths related to cancer in the year 1997 (National Cancer Institute of Canada 1997:20). The tables below represent the rates of incidence *(see table 1)* and mortality *(see*

table 2) due to cancer in Kings County. The table further breaks down the age distribution and cancer sites in Kings County for the years 1991 through 1995.

Table 1

County Incidence, NS 1991 - 1995

County : Kings

Cancer Site	Total	Age_70 under 70	Age_70 +
Stomach	25	7	18
Colon, Rectum	178	80	98
Lung, Pleura	203	113	90
Breast	155	92	63
Melanoma of Skin	38	25	13
Cervix Uteri	17	12	5
Corpus Uteri	19	10	9
Ovary	25	18	7
Prostate	214	79	135
Kidney, Ureter	52	32	20
Bladder	74	32	42
Hematopoietic	30	14	16
Lymph Nodes	81	49	32
All other Cancers	211	115	96
Total	1322	678	644

Table 2

County Mortality, NS 1991 - 1995

County : Kings

Cancer Site	Total	Age_70 under 70	Age 70 +
Stomach	25	5	20
Colon, Rectum	43	16	27
Lung, Pleura	148	64	84
Breast	43	18	25
Melanoma of Skin	1	0	1
Cervix Uteri	6	3	3
Corpus Uteri	1	1	0
Ovary	12	6	6
Prostate	55	7	48
Kidney, Ureter	12	6	6
Bladder	13	2	11
All Other Cancers	321	135	186
Total	680	263	417

(Nova Scotia Cancer Registry 1997).

AIDS Occurrences In Canada and Nova Scotia

In Canada there are no statistics which accurately indicate the incidence and mortality rate of HIV/AIDS. The issue of confidentiality and the 'social stigma' affiliated with this virus accounts for the under reporting of cases. The statistics provided in this section are only *reported* cases of HIV/AIDS in Canada and so it is imperative to remember that the 836 reported cases may represent only a portion of those Canadians affected by Acquired Immune Deficiency Syndrome (AIDS). This is representative of statistics since the early 1980's. The number of deaths due to AIDS reported since the beginning of the epidemic is 10,837. The number of those reported in the Atlantic Region (including NS, NB, PE, NF) is as follows:

Males	385
Female	41
TOTAL	426

(Health Canada, May 1997: 25)

The Nova Scotia Department of Health states that the number of AIDS cases reported since the illness was first diagnosed (1983-1995) by gender in Nova Scotia is as follows:

Male	196
Female	17
TOTAL	213

The only statistics that could be obtained by region in Nova Scotia are reported cases of HIV (1983-1995). There is no indication in this report of how this data is collected or how accurate these numbers are. This report maintains that in the Western region of Nova Scotia there have been a total of 41 persons with HIV (36 male and 5 female). (Nova Scotia Department of Health 1995: 12)

Who Could Use A Hospice In Kings County?

In order to provide a perspective on how many people in Kings County could use the service of a hospice program, the provision of statistics based on rates of clients using existing palliative care services has been compiled. However, it should be noted that not all of these clients could use an inpatient program, as well, there may be duplication of statistics as clients were not cross referenced. Nonetheless, throughout the month of June, 1997, the Valley Regional Hospital's palliative care nurse, reports that there have been 32 inpatient and 29 outpatient follow-up cases of clients in a palliative state of care. Meanwhile, the VON/PEP Supportive Care Volunteer Program Coordinator indicated that in the month of June there have been 38 individuals in Kings County drawing from these services. At the same time, VON Nursing Staff indicates that there are twenty-four (24) active palliative clients. Finally, Homecare Nova Scotia reports that there were approximately 14 individuals whose home services were termed palliative care in June.

Methodological Approach

Measures

The methods undertaken to gather information for this needs assessment include a mail survey and a series of semi-structured interviews. Both the questionnaire and the interviews posed the same questions. A cover letter explaining the needs assessment was included with the survey as well as an invitation to participate in same *(see Appendix 2)*. The survey consisted of eighteen questions specified in three sections *(see Appendix 3)*. The first section dealt with different types of needs (i.e., physical, psychological, social, spiritual, information and

financial) that persons living with a life-threatening illness and those who care for them would encounter. The physical, psychological and social needs questions included suggestions or hints, housed in brackets, in order to achieve clarity in the respondent's thought processes with respect to the nature of the complexity of these needs. Following the different types of needs questions was a definition of palliative care. The definition was used to ensure that the participants understood the meaning of palliative care. Finally, this section posed questions with respect to the respondent's familiarity with services and programs for palliative clients in Kings County.

The second section stated the definition of a hospice facility according to the mandate of the VON, Kings Branch. This definition was incorporated due to the unfamiliarity of free-standing inpatient hospice care as opposed to inpatient care provided in a hospital or long term care facility in Nova Scotia. It also provided additional clarity for the respondents to answer the question whether or not they felt the need to establish such a facility. Additionally, this section granted a check list of the types of services they would like to see offered in a hospice setting.

Finally, the third set of questions was demographic in nature, inquiring about their gender, age, education and the exact role they engaged with dying individuals.

A draft of the survey questions was reviewed and pre-tested by members of the Palliative Care Advisory Committee. The questionnaire was administered May 5 and July 27, 1997 with interviews being conducted between the dates of June 20 and July 25, 1997.

Sample Population and Sampling Method

In total, 374 individuals were approached to participate in the needs assessment. One hundred and fourteen (114) returned the questionnaire with 10 people interviewed, for a total of 124 participants. The response rate for this study was 33%. The sample population was selected from groups of persons who were knowledgeable about palliative care. Participation in the study was voluntary for all groups in the population. The sample consisted of the following groups:

- Individuals with a life threatening illness, families and significant others;
- Formal care providers: VON nurses, LPNs, Care Coordinators and Home Support Workers, physicians, clergy and complimentary health practitioners; and
- Informal care providers: VON/PEP Palliative and Supportive Volunteers, Friends Of Bereavement Support Group, Living With Cancer Support Group and Valley AIDS Concern Group.

Individuals With A Life Threatening Illness, Families and Significant Others

The sample list of participants for the dying, families and significant others was a *purposive* sample compiled by the VON nursing staff, the Valley Regional Hospital's palliative care nurse and discharge planning nurse, as well as the VON Volunteer Supportive Care Coordinator. Potential participants from the VON caseload (N=41) were sent a letter and consent form inviting them to join the study by the VON, Kings Branch Executive Director *(see Appendix 2)*. The letter gave the respondents the choice of having a personal interview or receiving a questionnaire by mail. Potential respondents from the Valley Regional Hospital

caseload (N=20) and clients of the VON/Volunteer Supportive Care Program (N=19) were contacted by phone and asked if they would like to participate in the needs assessment.

If the individual agreed to participate, a home visit interview was scheduled, or, they were sent a questionnaire by mail. Twelve individuals agreed to be interviewed, however two declined to include their information upon completion of their session. The remaining ten interviews averaged two to four hours, allowing time for emotional support to follow.

Formal Care Providers

The sample of formal care providers included in this study were: VON nurses, LPNs and Home Support Workers; Home Care Nova Scotia Care Coordinators, Physicians, Clergy and Complimentary Therapists.

The VON staff and HCNS staff (N=90) surveys were administered during regularly scheduled meetings. The respondents had the opportunity to either submit the questionnaire by mail or deposit same in the questionnaire box at the VON office.

Questionnaires for Physicians (N=56) were placed in their mail boxes at the Valley Regional Hospital, Eastern Kings Memorial Health Centre and Western Kings Memorial Health Centre. The option was to leave the survey in the box or return it by mail.

Administration of the questionnaires to the clergy population (N=20) was handled in a similar fashion to the physicians. The surveys were placed in the Chaplain's Room at the Valley Regional with the same options for return.

The final group in this category, namely the Alternative Health Practitioners (N=25) were contacted by mail. This method did not prove to be successful.

Informal Care Providers

Informal Care Providers such as volunteers and local support group members (N=93) were contacted at monthly meetings and by phone through the Coordinator and were asked if they would like to participate in the study. Those who agreed were given a questionnaire and provided with the same return options.

In addition, an ad was placed in the local newspaper and on the local cable TV network announcing the needs assessment and inviting the community to participate. This was successful in attracting only one individual to participate.

Methodological Issues

Various methodological issues need to be addressed. The sample population was drawn from caseloads of VON Kings Branch and Valley Regional Hospital. Given that the participants in the study included those in receipt of health care, directly or indirectly, they were considered to be a vulnerable and captive group of individuals. Lasagna (1981) contends that an ethical factor should be considered when conducting research with vulnerable and captive populations whether or not the subject or society receives any potential benefits from the study. The societal benefits of the needs assessment are numerous, however, the tangible benefits for the participants may not be as obvious. Yet, a typical response from the participants in this study is summarized in the words of a 74 year old widower:

> I'm happy to do it [participate in this study] because I don't often get a chance to help people much anymore. They're always helping me, you know. So it is nice to be able to do this. If taking part in this could help someone in the future I am glad.

It is important to acknowledge those who are in this study as well as those missing from this needs assessment. Recall that the sample population of 33% voluntarily returned the questionnaire and/or participated in the interview schedule. There are many reasons for people not responding to a request of participation in research such as: time constraints; poor levels of literacy; and avoidance of the topic of death. Furthermore, it has now been amply demonstrated that people who respond to research requests have differences from those who do not. Non-responders tend to be more dysfunctional in a variety of ways than do responders; that is, responders tend to be a biased sample of all service recipients (e.g., Bass 1982; Hayslip, Hoffman & Weatherly, 1990-91). This suggests that the participants in the present study, as a group, may be from among the more functional families or caregivers, with greater socioeconomic resources as well as those whose patient relationships were less impaired or whose illnesses demanded less strenuous care. An anecdotal reason for the low response rate might be that for some, the experience of caring for a loved one is over, death has occurred and therefore, a form of emotional closure has been achieved. Reliving the experience that might have been less than ideal and could be extremely painful.. Whether or not a more representative sample would have yielded more conclusive findings remains to be seen. This situation does suggest that if sound and productive palliative research on unfavorable outcomes of service is to be done, greater efforts will be required to obtain representative samples.

Data Analysis and Results

Analysis of the data varied depending upon the method employed. The questionnaire data were entered into *Excel* and percentages were obtained from coded responses. All percentages have been rounded to the nearest decimal point. Qualitative data collected from the survey and the interview has been analyzed for recurrent themes. Direct quotes or the 'voices' of the participants in the study are represented by a shaded gray background.

Background Characteristics of Sample Population

Of the one hundred and twenty four participants included in the study, ninety-one were female, twenty-nine were male and four did not indicate their gender. The mean age of the respondents fell between fifty and fifty-nine years.

A sizable number (40%) of respondents identified themselves at a graduate level of education. Nine percent of respondents attended university education, seven percent had college education, twenty-two percent had a high school level, ten percent represented trade school education, one percent had an elementary school education, while seven percent indicated 'other'. Four percent did not provide this information.

When respondents were asked what their relationship or role was to palliative care clients in Kings County, a majority (37%) reported that they were the family, friend, or significant other of someone who has *died*; thirty-five percent (35%) reported they were *formal caregivers*; ten percent (10%) reported they were the an *informal caregiver*; seven percent (7%) reported they were an *individual* with a life threatening illness; seven percent (7%) reported they were family, friend or significant other of someone who was *dying*; two percent (2%) reported their

relationship was *other* and two percent (2%) did not provide any data. Many people in the study held multiple roles, so categories were overlapped (i.e., a formal caregiver could be caring for a loved one at home). In addition, most people did not indicate their role as a formal caregiver.

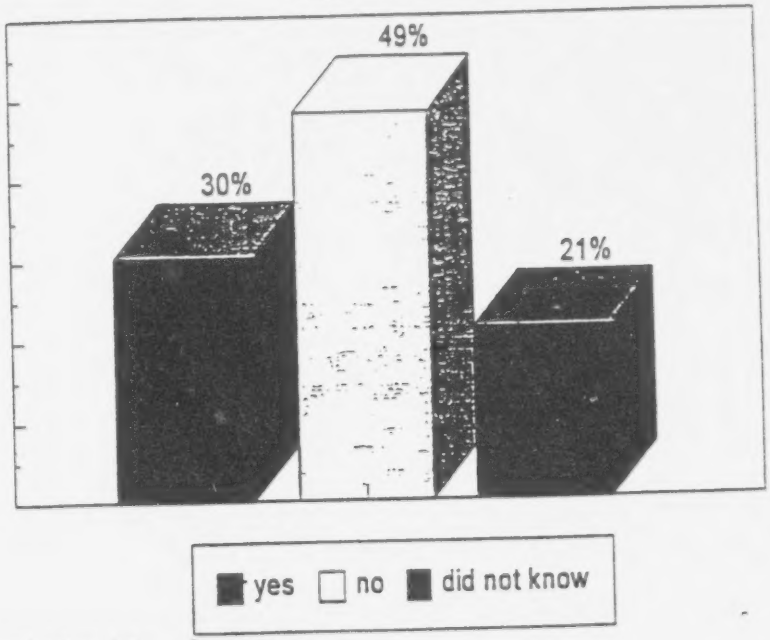
Physical Needs

Do you feel the physical needs (i.e., symptom and pain control, personal care) of the dying are adequately met in Kings County?

Nearly half the sample (49%) felt the physical needs of the dying were not adequately met, thirty percent felt the needs were adequately met and twenty-one percent did not know *(see chart 1)*.

Chart 1

Physical Needs



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Pain control & symptom management and physical care of the dying is a major worry for significant others and caregivers. Many patients with life threatening illnesses in Kings County experience problems with pain and symptom management despite the availability of effective medical therapies. Although medical therapies are available, it seems that accessing these therapies remains a problem. Many participants in the needs assessment expressed that the following barriers prevent effective pain & symptom management of the dying:

> Pain control is a difficult problem, the pain pump is not available in all areas and not all drug stores can fill them. Doctors are not up to date in pain management [i.e. clients are home out sight out of mind].
>
> Often the disease causing death is so dominant that little attention is paid to treating the lesser conditions which may be causing pain.
>
> Not all physicians are comfortable in appropriate pain management of dying patients. Doctors are still reluctant, on the whole, to order adequate pain medication.
>
> From personal experience pain control is an issue for me. I do not feel the doctors are able to give an adequate amount of pain medication at times. Some families and some physicians still are reluctant to allow appropriate levels of analgesia.
>
> Formalities often frighten and overwhelm the family by amount of care required for a terminally ill patient and often afraid to administer medication.
> I have experienced people dying in my home and have not been able to have the doctor involved, return calls or visit when requested therefore unable to meet the needs of my people.
>
> I feel doctors could move more quickly in regards to answering phone calls and questions [they all seem to be such a rush] when it comes to patients and family needing help we get put off.
>
> There are problems with obtaining orders for medication, payment & transport to the client are sometimes a problem. Even then we are limited and cannot always control pain and nausea.
>
> I was main support for a terminal cancer patient. There were times when we waited for over an hour for someone to come with pain relief medicine.

Some people have to wait to get pain medication when they are in great pain or distress and that's not right.

The person I took care of experienced great difficulty when she began taking morphine because of inadequate doses - but this was due to limitations of her physicians expertise.

There tends to be long delays at times while waiting for doctors to visit or give new direction to VON or other visiting nurses.

From my experience there appears to be a need for greater communication between professionals involved and the patient and family. Better communication would certainly help eliminate the confusion and frustration.

For some people it is obtaining enough care and help from persons trained to care for palliative clients is a problem.

I wanted to bring Mum home from the hospital. She could have stayed with me but all I could get from Home Care is 4 hours a week. She needed to have someone stay with her while I was at work. I couldn't get anyone to come in during the daytime. Four hours is not adequate and I couldn't afford to keep someone with her. Why did they make such a big fuss about Home Care if they couldn't provide it.

I had no time for anything but care for Mom. Home support program was limited. A couple of hours a week was not enough. Sure it gave me time to get the groceries but not much else. Taking a walk for pleasure was out of the question. My brothers and sisters had jobs, kids and other responsibilities. Also, they lived too far away to come and relieve me.

Lack of adequate training of home support and lack of current up-to-date information on pain control. Some are very fortunate to have a dedicated care team.

As a patient or client comes closes to death, I feel that his/her needs increase but the amount of help available to them (especially trained sensitive help) does not increase.

For some it is [physical needs are met], for others it isn't, largely dependent on families educational, financial and social status. Sometime dependent on the physicians knowledge and comfort dealing with the dying person.

Usually the patient only has 'professional' care for a few hours a day, then it is left up to family members to cope with the care of the dying when they are under stress and pressure and have full time jobs of their own.

Some respondents referred to care that is provided through the hospital.

Lack of beds for terminal palliative care & not enough home support for more terminal palliative cases to return home.

It seems that a hospital which is well equipped yet understaffed is the only option aside from being at home.

We need a place we can rely on to go for help when the hospital is over booked with patients.

While others were quite happy with the care they received.

We were very lucky. My husband did not experience any uncontrollable pain. He had patches that seemed to control his pain really well. Only on the day he died did he seem uncomfortable and I called his doctor and he came by to the house and gave him an injection that eased it.

I could call him (family physician) at anytime of the day. I even had his home phone number. When he was away he made sure I could get a hold of someone, usually the VON.

I can't speak for others. But in my case with my wife I felt the care was excellent. A very adequate combination of home care and in home doctor visits.

The girls from home support were good to us. They made sure that Mom had baths and did good things for her.

VON - palliative care team has been extremely helpful. There is good information if you know to call VON.

The VON are doing an excellent job in these areas - and for the most part. Home support is as well.

Only with the help of the VON, did I manage to get through the rough months of looking after my mother. The VON came in every day and towards the end twice a day.

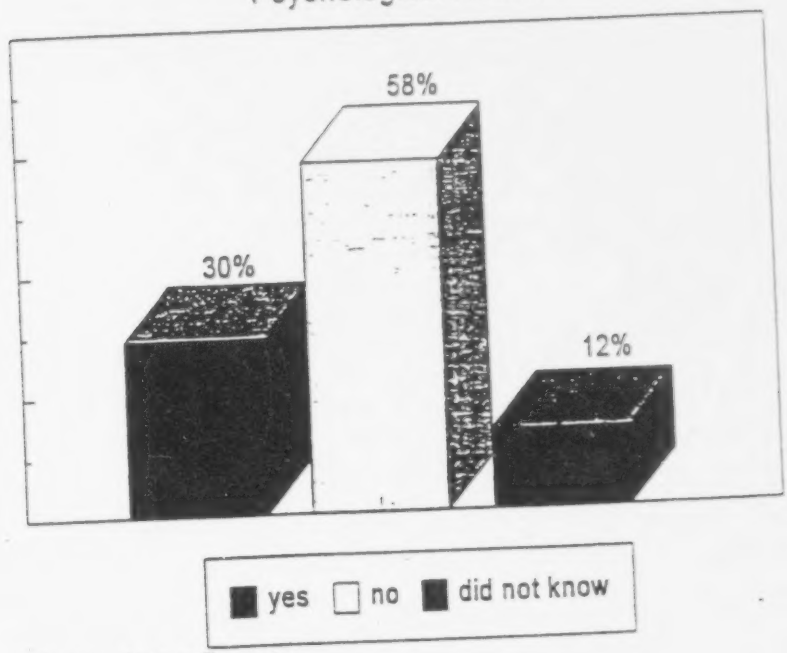
Psychological Needs

Do you feel that the psychological needs (i.e., emotional, mental well being) of the dying and those who care for them are adequately met in Kings County?

A large portion (58%) of the sample do not believe that the psychological needs of the dying and those who care for them are adequately met in Kings County. Thirty percent felt that the needs of the dying and those who care for them are met while twelve percent did not know *(see chart 2).*

Chart 2

Psychological Needs



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Living with and/or caring for someone with a life threatening illness can profoundly change one's life perspective and relationships. For some of those living with a terminal diagnosis, life plans and thoughts to the future are abruptly halted. For many caregivers the experience of having clients suffer pain or discomfort, as well the death itself can be emotionally draining. Some respondents stated the following feelings on the psychological needs of the dying and their caregivers in Kings County.

> This has been a totally new experience for me and it was difficult for me to accept and adjust to the sudden and terrifying changes that occurred before during and after my husbands death. Follow up by palliative care was TOTALLY lacking.
>
> Instead of " Living with cancer " too many are treated as "dying with cancer".
>
> Doctors give a diagnosis and then the person is left on their own! Not everyone has the ability to search for the help they need.
>
> I have requested a visit or phone call from the doctor involved and visit from another ladies minister and neither have responded.
>
> I know of no help in this category, only our minister was of any help.
> Due to lack of time to listen to information that client & caregiver are verbalizing. Many times the patient was alone. I had to work and even though she said she didn't mind, her biggest fear of dying was dying alone.
>
> I feel that they are usually put in a room and forgotten about because family members are present, so they feel nobody needs to enter the room besides family.
>
> The approach to psychological needs seems so cut and dry. In hospitals, they are so understaffed and time seems to be an issue. Mental & emotional counseling requires time, being educated & understanding of the dying process.
>
> In hospital there was little staff, time and resources to talk about these needs. With nurses changing daily there is not that one on one support person, or people, making daily or almost daily contact.

Remember the less well to do, have the same emotions when losing a loved one as the more well to do.

Some felt that the psychological needs of the dying and family were often dealt with on an individual basis.

One tends to be at the mercy of whatever support system they have in place which is almost always not adequate to meet needs.

For some their needs are more than adequately met with supportive friends & family, others do not have the necessary support.

This tends to vary from family to family in my experience, depending on the resources available in each family. Single parents, singles or those with AIDS may not have good support systems in place.

Family members are not at home as much to give the emotional support and I do not feel that the community as a whole accept dying and death as well.

Depends entirely on individuals, whether needs are recognized & appropriate help sought, help is there. So, education and encouragement to seek help are essential.

Others expressed a need for more services, education, information and awareness.

There is a need for more facilities and trained people.

Need more staff and funding.
Current staff are doing less with the few resources they have available.

I am not aware of any on-going care offered in this area.

The dying need someone to talk to consistently one worker or someone in the community they trust.

During my mothers 5 months of illness support came from VRH palliative care nurse, myself, and a few close family friends. We'd discuss a counselor but this wasn't provided. Again, health care professionals could be working together more closely as a team.

They have no one here to guide them through this, or be there to help them at their time of need.

We need more understanding for the caregivers and more of a chance to attend the support groups or workshops, with a respite visit during this time.

I feel there should be more teaching done to palliative staff i.e. home support workers, nurses and doctors. Plainly, more services are needed.

There definitely needs to be more support in this area! If there are support groups, patient's and their families should be told about them.

A more effective base of support could be used. Being able to access resources from one point is presently not available for clients in the county. Public awareness is also a big issue that needs to be expanded. It is a scary time for most people. They need trained caring people to care for them. They shouldn't have to search for resources.

We need an institution where body, mind and soul are treated as a whole entity and not separated. I believe in holistic medicine and it is practically impossible to care for all the needs of the dying in a hospital.

There are people who do not know where to turn for help and those who are afraid to ask for help, so deal with it alone.

Most families don't know where to go or turn for this type of advice except their clergy. Doctors don't counsel well or meet the needs in this field. In my case I would have liked to have had a better support network setup to help myself and children to deal with the stress involved while my wife was ill.

Others believe that the psychological needs of the dying are being sufficiently met and/or they have had only good experiences.

I feel that this support is available & adequate (even above average) if the patient and family seek them out.

All of the clients I have seen had accepted the fact that they were dying. Both their emotional & mental well being were surprisingly good. Family counseling has been fair, perhaps a little more time spent with family members would be more adequate.

We were emotionally and mentally well - both strong - helping each other.

There seem to be many support groups that have started up.

The psychological needs of the person I took care of were met by her friends. The caregivers held biweekly support meetings, which were helpful.

The psychological needs were very adequately looked after by the VON visits.

My experience has been positive in this regard. Many patients families have been supported by pastors and grief counselors.

This was my second involvement with death and I needed explanations as to what to look for as Mum got worse. Thanks to the VON for keeping me informed everyday.

Yes, with all the volunteers, VON, ministers and friends, sick people can depend on them emotionally.

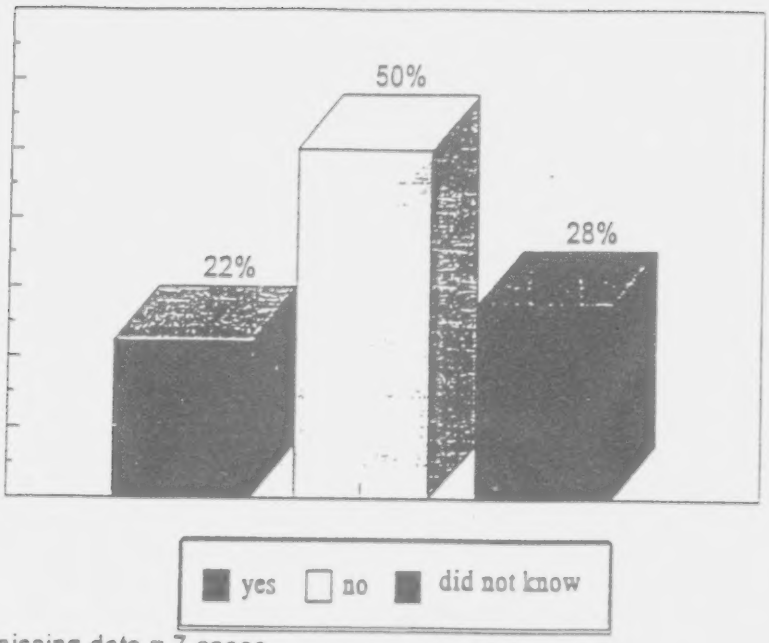
Social Needs

Do you feel that the social needs (eg., recreation, contact with others, support groups) of the dying and those who care for them are adequately met in Kings County?

Half (50%) of the respondents did not think that the social needs of the dying and those who care for them are adequately met. Meanwhile, twenty-two percent thought that the social needs of the dying and those who care for them are adequately met and twenty-eight percent did not know *(see chart 3)*.

Chart 3

Social Needs



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The dying and those who care for them do not experience or talk about their illness in a social or cultural vacuum. Everything that people feel, say, think, and do about their illness is culturally and socially mediated. There is often a stigma associated with a terminal diagnosis

that creates feelings of isolation and alienation for the sick and their caregivers. Maintaining social activities becomes a chore when you are physically unwell or unable to find proper respite for those to whom you provide care. Respondents in this study identified the following concerns about the social needs of the dying and those who care for them:

- Death and dying are dealt with on an individual basis. People die as they have lived. Therefore, if they did not have a strong social network before they got ill, it is not likely that they will have one when they are dying.
- Social needs are often left up to the family.
- People avoid individuals who are dying.
- Social contact is related to those who come to visit.
- Community is not aware of social support groups for the dying and those who care for them.
- There are not enough people educated about the social needs of those who care for the dying.
- Lack of social support for the dying.
- Transportation is a problem.
- Lack of support for the caregivers.
- There is not enough respite care available to attend support groups.

Some specific comments that were provided are:

> The view & understanding of social support seems minimal. In general, I think it's limited. I think we are definitely lacking in support for caregivers.

> In summer or good road conditions people tend to visit but in winter people are too nervous to walk or drive.

There can always be improvement in this area. Many older people have lived here for awhile and have good support but younger people may not have the same social support systems developed.

Once confined to home most of the time due to weakened condition, social contact is dependent upon those who come to the home. Caregivers often are not free to attend meetings and the present one per month for cancer patients families is not adequate.

There is very little planned "recreation", there needs to be more contact with families in like situations i.e. support groups especially after death.

I feel a pamphlet with available resources would be a good idea, allowing the client & family's to decide what resources they need & want to access.

I do not feel there are enough support groups or at least information about them given to those who care for the dying.

Most folks (in my experience) don't see the need for a social side to death and dying. More education = more demand and usage.

Transportation, awareness, and a central location to socialize could be improved.

The Valley Regional Hospital employs a chaplain. Also, the ministers I have met are very compassionate & more then willing to help out.

I feel this is difficult to determine as so many people live in remote areas.

Sometimes if no immediate family members are present, then there is nobody there at all.

I feel that they are usually put in a room and forgotten about because family members are present, so they feel nobody needs to enter the room.

People seem hesitant to call for help/support. There is very little planned "recreation", there needs to be more contact with families in like situations i.e. support groups especially after death.

When we see clients we really encourage them to live while they can but when it comes to the social needs when they are really palliative, PEP and the minister seem to be the only social part of a families lives other than their own.

If the emotional needs are not met how can the social needs be met. I do not know of any support groups for the dying and those who care for them.

I feel that I was alone during that period, no one seemed to be there for us except the family and our minister.

Our patient had adequate visits by his friends and relatives. They were all very thoughtful.

Again, I have requested a particular ladies' minister to visit, also church groups and got no response. I did have involvement through VON Supportive Care.

Except for a handful of people I was needed all the time. The group over extended themselves to help but there was no one to help her 15 year old daughter.

No, it's not but I think it depends on the individual as to whether it's necessary or not. Some sick people might just want close family and friends around because other sick people might make them sad.

During her illness the only contact mom had with other cancer patients was during chime. It perhaps would have helped to meet others out side the hospital setting.
The VON were the only people who visited us daily. I had no support had to deal with everything alone.

There are good support groups, but not always available at a convenient time for caregivers.

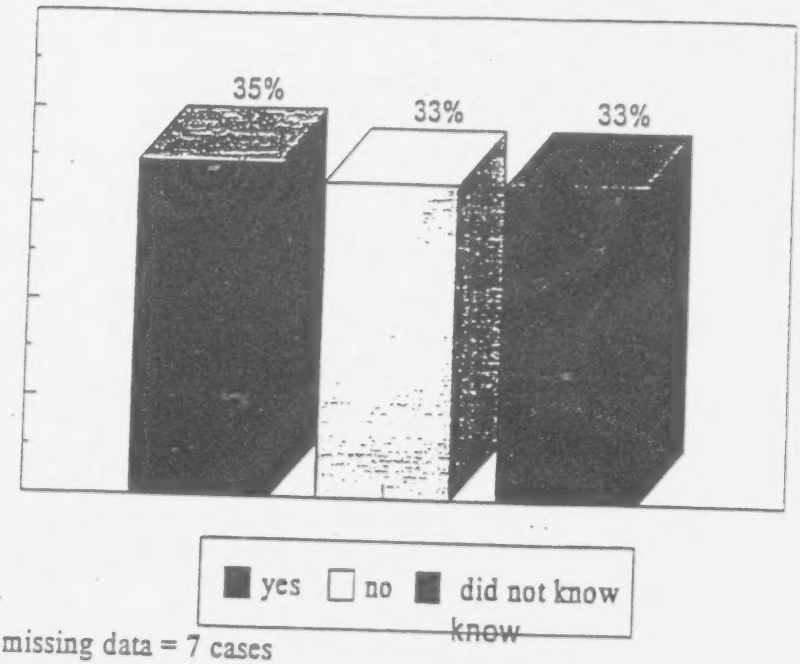
Spiritual Needs

Do you feel that the spiritual needs of the dying and those who care for them are adequately met in Kings County?

Thirty-three percent of the sample population believed that the spiritual needs of the dying and those who care for them are not met in Kings County. Thirty-three percent believed that the spiritual needs of the dying and those who care for them are adequately met and thirty-three percent did not know.

Chart 4

Spiritual Needs



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Life threatening experiences provoke a re-examination of values and priorities. Respondents in this section indicated the following:

- It depends on the individual. If they were active members in a church they had good support. If they were not active members in a church they tended not to feel the same sense of spirituality and the support it was capable of offering.
- Not adequate support for people outside the Christian faith.
- Spiritual counseling from a non-denominational faith is desired.
- Spirituality is a personal issue that is dealt with on an individual or family level.
- Many felt that there was adequate support from clergy.
- Clergy have to visit many people and time restraints are an issue.
- Home visits are desired on a more frequent basis as the need increases.
- Chaplain at the Valley Regional Hospital was greatly appreciated.

Some specific comments on the spiritual needs of the dying and those who care for them are:

Personally, I'm not an active outward Christian and that seems to be the only spiritual support here in the Valley.

For those who are receptive to such support. Most clergy are important and very supportive.

For recognized religion and those who seek chaplain or minister (Christian) help, yes their needs are met. But for other religions - Hindu, Buddhist, Jewish, Muslim etc. I don't think so. Some might prefer non denominational spiritual counseling.

Often on an individual basis it is addressed through the families own minister or priest etc., but I feel some would enjoy the benefits if something was available on a " non - denominational level".

In general it seems pastors are quick to respond to visit where there is a need. The chaplain in hospital is a wonderful new asset.
Those not connected to an established church don't always have needs met. Even in churches death is not always dealt with in a life giving manner.

To me, spirituality is a personal (not religious) thing. Spiritual needs have to be met by ones own definitions and not organized religions.

Those in hospital have access to a chaplain. In the community those that belong to a church probably have support, however there are many (those not affiliated with a particular church who have no one to confide in.

Basic thinking for me is that this would be a very private concern and for the most part an issue that family should deal with.

Most of us are ill prepared to accept a developmental biological approach to living and dying phases of a mysterious process.

This is a very difficult question. I feel the ' spiritual needs ' is something very personal and profound & it would be inadequate for me to assume that because we have pastoral counseling, that this results in spiritual fulfillment for all.

I don't feel in many cases the ministers or lay members of the church are involved enough especially prior to death. Maybe that is a problem in our general society. They may feel they would be interfering.

It is virtually impossible with staff shortage in hospitals to adequately look after the spiritual needs of the dying. In fact one chaplain cannot do the work.
The minister is the only individual who visits regularly.

Although the minister visited periodically, it was no where enough. Lay people helped with poetry but I would have liked more from the church than a visit 3 times in 8 months.

Those visibly connected with churches have their needs met. Others fall through cracks.

There is not always people available to help and listen, some people can find peace before they die and their friends family can find closure after they die from helping themselves.

For my mother it was; her minister visited regularly as well as other pastors she knew and also the clergy at VRH visited.

Mom was very private in this aspect. She and I talked openly about death. She wasn't afraid to die. She did share some feelings with an ordained minister who she felt very close to and we prayed together, many times at her request.

Even our own minister didn't visit regularly. We saw him once in hospital and once at my home. He really ticked me off!!

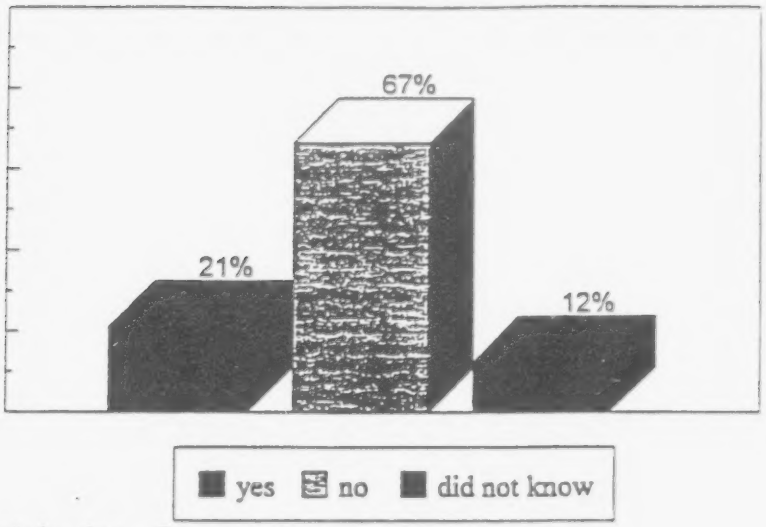
Information Needs

Do you feel that the information needs (i.e., understandable information about palliative care, life threatening or terminal illness, loss, grief, death planning and bereavement) of the dying and those who care for them are adequately met in Kings County?

A sizable portion (67%) of the respondents did *not* believe that the information needs of the dying and those who care for them are adequately met in Kings County. Twenty-one percent believed that the information needs of the dying and those who care for them are adequately met and twelve percent did not know *(see chart 5)*.

Chart 5

Information Needs



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People have different informational needs. Some desire only the basics, while others desire a more sophisticated and complex interpretation of their terminal illness and palliative care issues and opinions. It is important that whatever an individual requires is attainable and

easy to understand. Some general concerns about information needs of palliative care in Kings County are:

- Information is not easy to obtain.
- Obtaining information is left up to the families or significant others.
- Poor community awareness of palliative care, unless they have been faced with caring for someone.
- Poor public awareness of where to get information.
- VON are a good resource for information.
- Valley Regional Hospital palliative care nurse is a good resource for information.
- Physicians do not know where to tell patients to get information.
- Health care providers are not providing the families and significant others with enough *easy to understand* information.

Some specific comments regarding the informational needs of palliative care clients in Kings County are:

> Many people do not know how to access information that is available. Many relinquish this role to their physician
>
> We did receive good information but not through the standard channels, so I don't know if others in similar circumstances would have had access to it.
>
> It can be very frustrating not knowing or understanding the stages of palliative care. For someone going through it, information is an asset & sometimes is not available or people don't know where to get it.
>
> Getting information on palliative care is helper skelter.

Good information is available if you have the energy and know how to go after it, but basically readily accessible information is not.
In that my late wife was terminally ill for three months and no assistance was forthcoming other than from the palliative nurse at the Valley Regional Hospital.

If it is, where is the information? Why isn't it circulated to any and all health care practitioners.

Physicians for the most part are not giving this information to their patients.

I don't feel that family members are notified of what is available for them if families don't ask.

The only assistance I had in this regard was the doctors and the VON nurses.

I know the VON talk to the dying & those that care for them about the above information and I have seen written literature in their homes.

With the changes in health care and more terminally ill people are dying out of hospital, we who care for these people were not informed as to whom to call. If we call 911, we would have a police investigation.

Need more sit down-time to inform patients and family members. Take time to explain this in much more detail. No doctor ever explained anything to my family! I guess it was taken for granted that we knew most of what was happening and going to happen.

I was asked to leave a cancer society meeting because I wanted to discuss all alternatives. I asked for just some ideas to what could be tried. They refused. Too much palliative information is beyond educational levels of patient and family.

No, because there aren't always people there to tell you what your going to do or what's going to happen and it gets confusing for everyone.

Again cooperation is desperately needed - especially in this area. Doctors and other care givers usually give very little information to either the patient or support person.

We need more of their care, they do not have enough permission to meet the demand.

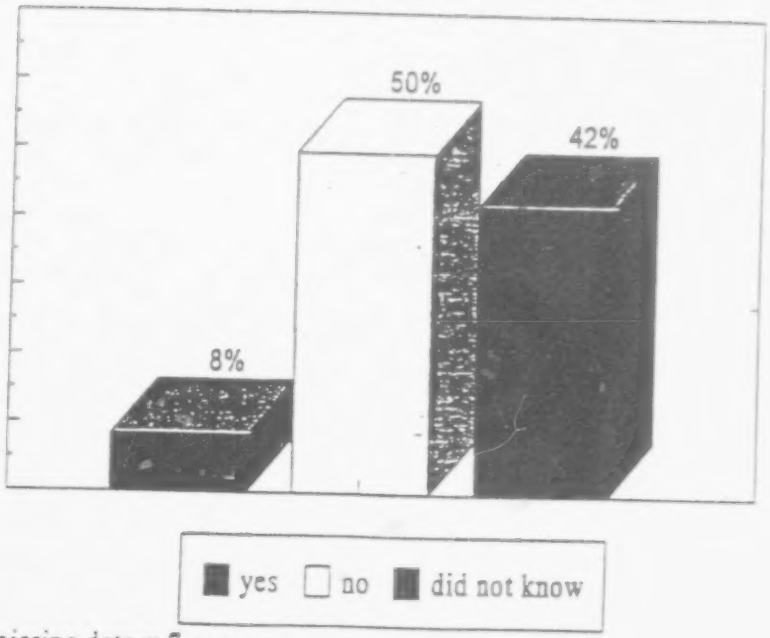
Financial Needs

Do you feel the financial needs of the dying and those who care for them are adequately met in Kings County?

Half of the sample did not feel that the financial needs of the dying and those who care for them are adequately met. Forty-two percent did not know if the financial needs of the dying and those who care for them are met and eight percent felt that they were adequately met.

Chart 6

Financial Needs



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Attaining the resources to support someone with a terminal illness can be a financial burden. Federal and provincial health insurance programs do not provide coverage for all medications, supplies, equipment rentals and services that a person living with a life threatening illness may require. Not everyone who is in a palliative state of care has private medical insurance coverage to fill in the gaps of Medicare and even then, a lengthy ailment can drain private claim coverage. Provision needs to be made so that caring for a dying loved one does not create economic hardship. Some distinct concerns that were expressed on financial resources include:

- Palliative care is expensive, in particular medication, chemotherapy and home support.
- Many requirements for care are not covered by Medicare.
- Many requirements for care are not covered by private medical insurance.
- Transportation costs are not covered by Medicare.
- Often individuals are required to use personal savings or retirement funds to help pay for care expenses.
- Lower economic groups fall through the 'cracks' and do not receive the care they need.
- Clients are not aware of financial assistance programs.
- The process of obtaining financial assistance tends to be an unnecessary 'paper chase'.

Specific comments that were provided on the financial needs of the dying and their care providers.

Many patients who I have are under ' 65' and therefore, often have to dip into personal, spousal, family savings to pay expensive costs for prescriptions, renovations and care, especially pain medications which should be covered under MSI and Medicare.

I got the impression from my discussion with a care coordinator, that obtaining financial assistance could involve something of a run around. I think that the eligibility criteria should be relaxed.

Sometimes people who need expensive medication cannot afford them, leaving the person in pain until arrangements are made through Social Services for money to help pay for them.

If people are aware / informed that palliative care is available for free yet with limits. It is not widely publicized. But, if a family is poor, they may assume that a hospital is the only free option for them.

Only the very affluent can afford the help needed to assist a terminal patient living alone who wishes to die in his/her own home.

I do know that the patch (pain medication) is expensive and a couple of clients under 65 found this expensive, one had to wait for word back or financial assistance. I believe he died either a day after or before the patches were available.

Single people and AIDS patients who do not have family or 'other' support struggle. They are young and don't have savings or retirement packages to tap into.

There's money for lots of things but when it comes to dying it is forgotten about. We can't afford to have people die in comfort in Kings County.

Our age makes some drugs available through MSI, such as the cost of ambulance transport. Even so, dying is costly in many ways e.g.. travel to Vancouver for only available medical bronchoscoloy. The limits of reasonable care are not clearly defined.

Government health care cutbacks prohibit enough home care in many cases.

Medication is very expensive and a lot of people can not afford them. Some medications are covered by local organizations, but usually the spouse or caregiver ends up doing without to cover the bills.

I think that the costs of necessary health care services are adequately covered. Advice regarding the management of estates, funeral costs, etc. may be an unmet need in some cases.

Cost of morphine for pain control is obscene! Patients who are not covered by pharmacare must virtually declare bankruptcy or meet the cost alone.

Unless these people have some kind of insurance their needs aren't met. Most can't afford the help or medication they need.

A lot depends on the amount of money you make. There are people out there who can't afford things like pain medication or chemotherapy.

The people that I care for are financially able to meet their needs, but I am aware of situations where those who care for family members are unable to have a break because of financial restraint.
I do not know how I would have paid for heat and food if I had not cashed in the RRSP's. Nothing was given to help me defer cost to me for the trips to Halifax for chemotherapy.

Many families suffer additional grief and stress, because of the added financial burden placed upon them during the time of illness and death.

There were times Mom suffered from malnutrition because of her chemotherapy but also because there wasn't enough income for her to get the food she really needed .

Their budget doesn't seem to be adequate enough to meet the demands.

When you only have the old age pension there isn't a lot of money left over. This was a big worry to my mother. .

Palliative Care Programs and Services In Kings County

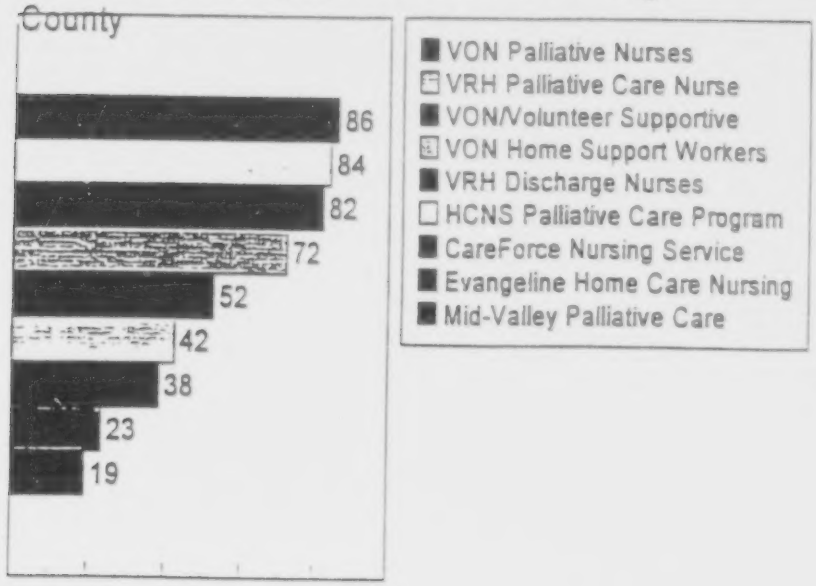
Are you familiar with the following Palliative Care programs and services in Kings County?

A large majority (86%) of the *total* sample population indicated that they were familiar with the VON palliative care nurses. Meanwhile, eighty-four percent were familiar with the palliative care nurse at the Valley Regional Hospital; eighty-two percent were familiar with the VON/Volunteer Supportive Care program; seventy-two percent were familiar with VON home support workers; fifty-two percent reported familiarity with discharge planning nurses at Valley Regional Hospital; thirty-eight percent were familiar with CareForce Nursing Services (private nursing service); twenty-three percent were familiar with Evangeline Home Care Nursing (private nursing service); and nineteen percent were familiar with the Mid-Valley Palliative Care Group. *(see chart 7).*

Care Nursing (private nursing service); and nineteen percent were familiar with the Mid-Valley Palliative Care Group. *(see chart 7).*

Chart 7

Palliative care programs and services in Kings County



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percentage of respondents who answered 'yes'

Respondents were further asked if there were *other* programs that they felt served palliative care clients in Kings County. They reported such programs and services such as, Canadian Red Cross Society, Canadian Cancer Society, Living With Cancer Support Group, Being With

Dying Support Program, Life Line Oxygen & Medical Supplies, local pharmacies and local Churches.

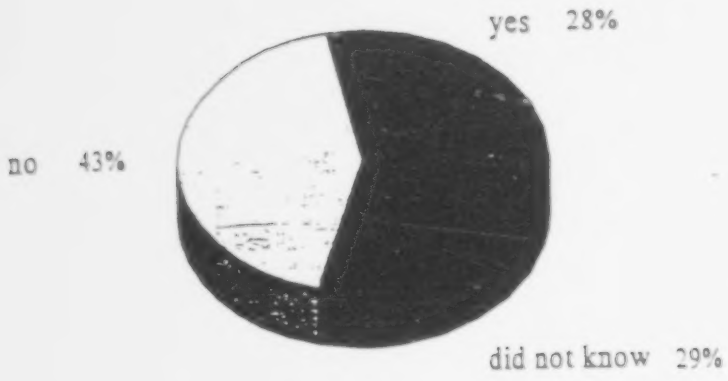
Critique Of All Services and Programs For Palliative Care Clients Presently Available In Kings County

Considering the programs and services that are presently available for the dying and those who care for them in Kings County, do you feel that all the needs are adequately met?

Forty-three percent of the participants did not feel that the existing palliative programs and services adequately met *all* of the needs of the dying and those who care for them. However, twenty-eight percent felt that they did and twenty-nine percent did not know. *(see chart 8).*

Chart 8

Do you feel the needs are adequately met?



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Common concerns of the existing palliative care programs and services that were specified are:

- Care is fragmented. Services and programs are not coordinated and integrated. This has caused poor communication between local health care providers.
- 24 hour care, 7 days a week is not provided
- Approach to care is not holistic. Emphasis is on meeting physical needs and ignores the psychological, social, spiritual, information and financial needs that an individual desires.
- Assessment procedure of home care for clients is not standardized.
- Care is crisis orientated and not preventive.
- Medical equipment, supplies and prescription are difficult to obtain.
- Not enough respite care available in the home.
- Too many health care providers entering the home.
- Hospitalization is the only option when support and finances are insufficient.
- Hospital is not the appropriate place for care because the focus is on acute not palliative care.
- Hospital does not provide enough palliative patient beds.
- No assistance for families or significance others with the transition phase of the patient from hospital to home.
- Inadequate training of health professionals on palliative care.
- Inadequate education on pain & symptom control management of physicians.
- Difficulty contacting health care providers, especially physicians.

- Poor public relations on the care that is available. There is not one central point for all information.
- Programs and services that are offered are not flexible to individual situations.
- The community is not aware of existing programs and services for palliative care clients.
- Not enough funding provided to existing programs and services for palliative care.
- No financial compensation for families or significant others who end or limit employment to care for loved one in the home.
- No follow up care for families or significant others after a lengthy illness of a loved one.

The suggestions and/or modifications that participants in this study identified as possible improvements for palliative care programs and services that are presently available in Kings County included:

- Integrate and coordinate programs and services. Use the 'team' approach to provide care.
- Create one central access point for palliative care clients.
- Educate health care providers about palliative care.
- Educate physicians about pain & symptom control management
- Limit the number of caregivers entering the home to 3 or 4 persons.
- Increase the number of hours of respite and home care services in the home.

- Build a hospice and have all services and programs for palliative clients originate from the facility.
- Increase public awareness through the media, pamphlets, radio, etc.,

Freestanding Hospice Facility In Kings County

Do you feel that there is a need for a free-standing hospice facility in Kings County?

An overwhelming portion of the sample (87%) felt that there was a need for a free-standing hospice facility in Kings County. Only one percent felt that there is not a need for a hospice and twelve percent did not know *(see chart 9)*.

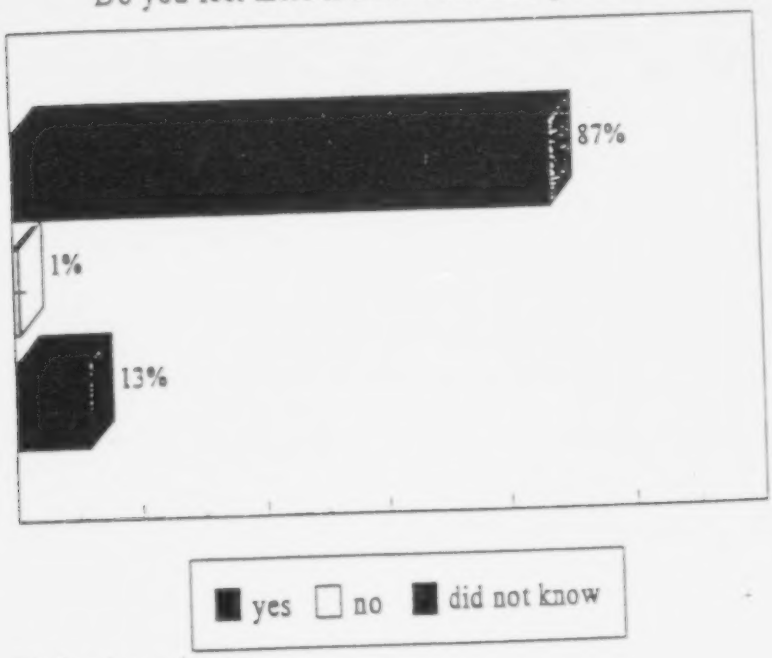
Freestanding Hospice Facility In Kings County

Do you feel that there is a need for a free-standing hospice facility in Kings County?

An overwhelming portion of the sample (87%) felt that there was a need for a free-standing hospice facility in Kings County. Only one percent felt that there is not a need for a hospice and twelve percent did not know *(see chart 9)*.

Chart 9

Do you feel there is a need for a hospice?



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Specific comments on the need for a hospice that were reported are:

There is a need for a place to live until death that frees family to be family. The way it is now I had to spend all my time either providing physical care for Mom or I was taking care of my kids. There was not a lot of time to just visit and talk with Mom.

I believe that there are still persons in this area who are 'falling through the cracks' and either don't have the monetary or family resources as well as external supports to deal with a terminal illness as it is often a long process.

In a situation where a loved one has to remain at home with a caregiver who is exhausted with the care & worries about the person dying at home and doesn't want the loved one to die at home. There is no other place to go if the hospital will not take them.

We need more help for those alone (with no spouse). We need a place that is like home but has adequate facilities for pain control. A place where the family and even pets can be kept near.

Single people & people with AIDS have nowhere to go to receive holistic care. The hospital is too busy and not adequate. Home care workers are not always understanding workers.

I think that peoples' needs would be better served in a hospice when home care is not possible than in hospitals. With so few hospital beds available, I feel there is a need for a place where family can place their loved one and not feel guilty about taking care of them.

We need a hospice where the dying and the support people, family etc. are accepted, nurtured, and made comfortable about what is happening and what will happen as the end draws near.

We need an open place that people know about and do not have to look for.

Everyone needs a loving and caring environment where they know they are wanted and will have the help, respect and privacy desired during their last days.

It would help to raise awareness of issues surrounding death and dying.

Some people do not want to go to the hospital, but they or their caregivers are afraid to be at home.

Some families are unable to cope with caring for a family member dying in the home.

For some persons, home is the only alternative for them near the end of their lives. Another choice for persons and families where critical medical needs can be met would be a comfort for many families.

Now that hospitals are discharging terminally ill patients as rapidly. I would say that a hospice in Kings County would be a tremendous achievement.

All needs can be better met in an atmosphere of love, care & compassion. The active treatment in hospitals is not geared to total care of the person.

There are some whose families are unable to care for them at home but do not wish to be in hospital. With long term illness, respite care offered in a hospice center would be a very nice alternative for both client and family.

As many people become more stressed emotionally as well as financially, this feels like a good idea. This would also provide care for those who live apart from family or are unable to receive the overall support they need.

To me, home is no place to die, people have to live there afterwards.

A 'safe' haven for loved ones at a time when family/friends may not be equipped either physically or emotionally to carry on their own.

At present, the services for palliative seems so scattered and if a hospice could localize these services it would be easier for a caregiver to find the adequate care needed, and it would give the family peace of mind in knowing the staff would be trained properly. People are often forced to use less qualified individuals for care either because of availability of qualified workers or obviously money or lack of.

Dying in a homelike atmosphere would be so much more comfortable than the ICU.

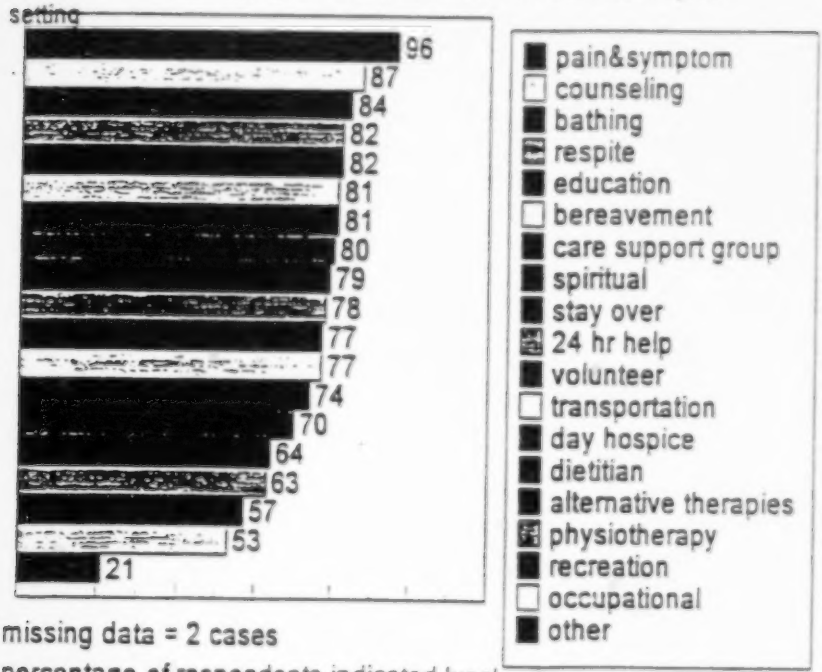
There should be a more central place that can draw all these supports closely together and thus, work more closely and efficiently with families and patients to make informed, educated choices and decisions.

The hospitals no longer want the dying, and they badly need a place to spend their last days in peace and comfort.

offered. fifty-three percent felt *occupational* therapy should be offered. and twenty-one percent felt there should be *other services* available *(see chart 11).*

Chart 11

Types of services or programs that should be offered in a hospice setting



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percentage of respondents indicated 'yes'

The additional services or suggestions that were requested are as follows:

- Pet therapy
- Music therapy
- Meditation room
- Hair and skin care
- Child care while visiting or children's play area
- Special equipment rental and orientation to them
- Provide a 'home like' environment
- Render financial assistance and planning
- Not to make judgments of the client and/or the families or significant other's lifestyle
- Avoid religious proelytizing
- Avoid over regulation of the hospice and allow for flexibility
- Avoid duplication of services that could be obtained elsewhere

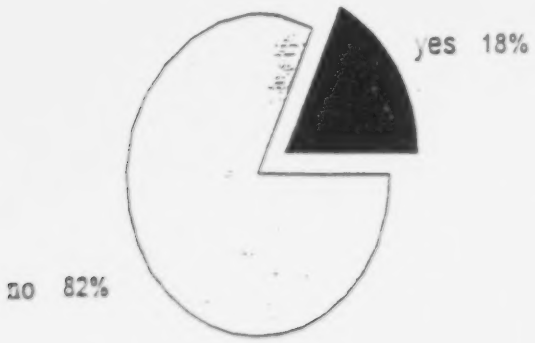
It was further suggested some of these services could be offered on a part-time basis or at the request of the clients. Moreover, many stated that it would be an ideal place to orient and coordinate all services for palliative care clients in Kings County, providing one entry point for all persons.

Reasons For Not Supporting A Hospice

Just eighteen percent of the population reported they would not support the concept of a hospice if one was made available and eighty-two percent had no reason for not supporting a hospice. *(see chart 11).*

Chart 11

Anything that would prevent you from supporting a hospice?



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The specific reasons provided, that would prevent some individuals from supporting a hospice facility in Kings County, can be summarized as the following:

- Belief that family and friends should take care of the dying in their home

- Financial expense of running and setting up a hospice on the health care budget
- Fear that a hospice would take away funds or emphasis from providing care in the home

Conclusion

Palliative care strives to meet the needs of those dealing with life threatening illnesses, as well as the needs of those who care for them. In a holistic approach to care, the physical, psychological, social, spiritual, informational, and financial needs of the dying and those who care for them need to be met. The body, mind and soul of humans are not separate entities that can be divided and cared for separately. The information gained through this study process suggests that:

1. There are an array of valuable palliative care services currently being offered in Kings County
2. Existing services need to strive toward increased coordination and integration
3. More information is required about existing services
4. There are clear gaps in the service provision
5. Existing services should be enhanced
6. The palliative care nursing provided by the VON is crucial in meeting nursing needs, as well as psychological, social and information needs
7. The palliative care nursing position at the Valley Regional Hospital is filling a key role in the provision of information and psycho-social support
8. A hospice would fill a pressing need in Kings County

Munley, Ann. (1983). *The Hospice Alternative: A New Context for Death and Dying.* New York: Basic Book Publishers.

Kastenbaum, Robert. (1995). *Death, Society, and Human Experiences (5th ed.)* Columbus: Merrill Publishing.

Ross, M. M. and B. MacDonald. (1994). 'Providing Palliative Care To Older Adults: Context and Challenges'. *Journal of Palliative Care* v10:4, 5-10.

Saunders, Cicely. (1990). *Hospice and Palliative Care: Interdisciplinary Approach.* London: Edward Arnold.

Senate of Canada. (1995). *Of Life and Death: Report of the Special Senate Committee On Euthanasia and Assisted Suicide.* Ottawa: Minister of Supply and Services Canada.

Von Bommel, Harry. (1992). *Dying For Care: Hospice Care or Euthanasia.* Toronto: NC Press.

Zimmerman, Jack. (1981). *Hospice: Complete Care for the Terminally Ill.* Baltimore: Urban & Schwarzenburg.

Mind, Body, and Soul:
Exploring The Need For A Hospice In Kings County

Recommendations

Recommendations

In light of the literature review, focus group meetings, the information gathered in the United Kingdom and the Kings County needs assessment, the following are the recommendations of the researchers. These recommendations fall into two interconnected categories, one specific to the creation of a hospice in Kings County, the other regarding the co-ordination of already existing services.

Hospice:

1. The VON Kings Branch proceed immediately to conduct a feasibility study into the creation of a free-standing hospice. In conducting this study, it is recommended that the following be considered:

    A. The goals and objectives for the hospice;

    B. The physical layout and design;

    C. Types of services to be offered;

    D. Staffing (including the role of volunteers);

    E. How the hospice will fit into the existing continuum of services;

    F. The proposed catchment area;

    G. To look at funding, financing, legal and regulation issues;

    H. Appropriate management structures;

    I. Suitable purchase, rental, or leasing arrangements of property;

    J. Fund-raising strategies;

    K. Public education strategies.

General

1. That services and programs for the dying and their important ones be more fully integrated and co-ordinated. That a central entry point for all programs and services for all palliative care clients be established while respecting the value of autonomy for some programs and services;

2. Provide more holistic health care with greater emphasis on psychological, social, spiritual, information and financial needs;

3. Provide preventative care not crisis orientated care;

4. Provide 24 hour care, 7 days a week;

5. Increase accessibility to formal caregivers, especially physicians;

6. Review the assessment procedures of the Home Care Nova Scotia. Assessments of palliative clients must be flexible enough to allow for increase care as the need increases.

7. Increase accessibility to medical equipment, supplies and prescriptions;

8. Provide assistance to families or significant others with the transition phase from hospital and home;

9. Establish additional programs that provide ongoing support for caregivers and increase respite care for individuals who care for the dying in the home. Furthermore, provide follow up care for families or significant others after a lengthy illness of a loved one;

10. Provide further education programs and information in Kings County for professionals and the general public to raise the level of understanding concerning palliative care services and their underlying philosophy and principals. As well, increase education and information to caregivers in Kings County on pain and symptom control management;

11. Increase funding to existing programs and services for palliative care

Legislative
Committees Office
House of Assembly
Nova Scotia

3rd Floor, Dennis Building
1740 Granville Street
PO Box 2630, Station M
Halifax, Nova Scotia
B3J 3N5

December 1, 2003

Hon. Ron Russell
Minister
Transportation & Public Works
Johnston Bldg., 1672 Granville Street
Halifax, Nova Scotia
B3J 2N2

Dear ~~Mr. Russell~~ Ron:

On Thursday, November 20, 2003 the Standing Committee on Veterans Affairs has met with members of the Royal Canadian Legion - Nova Scotia/Nunavut Command.

During this meeting the issue of full service gasoline stations was discussed in which the Westville Irving Service Station was mentioned. As stated this service station is not only a self service station but is designated as a provincial rest stop, which is inaccessible to veterans, seniors, and disabled persons, and that this venture may have received provincial government funding and as such should have full service accessibility available for those in need.

Therefore, a motion was passed by the Standing Committee on Veterans Affairs to write to the Minister of Transportation and Public Works for information confirming provincial funding to the Westville Irving Service Station and for the Department to look into providing full access service to veteran, senior and disabled motorists who frequent this establishment.

Enclosed is a copy of the Hansard transcript of the meeting for your perusal.

The Standing Committee on Veterans Affairs looks forward to hearing from you on this matter.

Sincerely,

Mr. Michel Samson, MLA
Chairman
Standing Committee on Veterans Affairs

MS/dh

Encl. (1)

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Nova Scotia
Transportation and Public Works
Office of the Minister

PO Box 186
Halifax, Nova Scotia
Canada B3J 2N2

Our File Number

December 17, 2003

Mr. Michel Samson, MLA
Chairman, Standing Committee on Veterans Affairs
3rd Floor, Dennis Building
PO Box 2630, Station M
Halifax, Nova Scotia
B3J 3N5

SUBJECT: Full Service Gasoline Stations

Dear Mr. Samson: Michel

I am writing in response to your letter of December 1, 2003, requesting confirmation of provincial funding for the development of the Pictou County Rest Area and seeking provision of full access service at the fuel pumps.

I can confirm the Department of Transportation and Public Works did provide the proponent with seed funding. In order to qualify for this funding, the development was required to meet certain rest area criteria. These criteria deal with very basic driver amenities such as public washrooms, telephones, parking and tourist information. There was no requirement that the rest area provide food or fuel services. These are additional measures the proponent provided of his own accord.

Although the department did provide seed funding, the rest area operates as a private facility. The department does not have any jurisdiction on the business operations provided by the proponent.

The concerns of your committee will be forwarded to the proponent for his consideration in assessing the services provided at this site.

With personal regards,

Ronald S. Russell, CD
Minister

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APPENDIX B

Veterans Affairs Canada | Anciens Combattants Canada

Atlantic Regional Office, 40 Alderney Drive, Dartmouth, NS B2Y 2N5

January 30, 2004

Mr. Michel Samson, MLA
Chairman, Standing Committee on Veterans Affairs
Legislative Committee Offices
3rd Floor, Dennis Building
1740 Granville Street
P.O. Box 2630, Station M
Halifax, Nova Scotia
B3J 3N5

Dear Mr. Samson,

During our briefing of the Parliamentary Committee, you raised the question of payment for gym memberships. The policy has now been reviewed and remains unchanged.

The policy is as follows:

3.0 POLICY

3.1 Swimming and other exercise therapy cannot be approved if it is determined to be solely for recreational purposes.

3.2 District Medical Officers or the Regional Medical Officer may approve swimming or other exercise therapy programs on a case-by-case basis only:

a) for rehabilitation of an acute condition or of an acute flare-up of a chronic condition requiring a short period of rehabilitation;
b) if the therapy is under the direct supervision of a provincially-licensed health professional; and
c) if it is an integral part of a structured rehabilitation plan.

We hope this provides you with the information you need. A longer reply on all your questions is being completed and will be forwarded as soon as it has been completed.

Sincerely,

B Gallant

Barry Gallant
A/Associate Regional Director General
Atlantic Region

Canada

Veterans Affairs Canada | Anciens Combattants Canada
Atlantic Regional Office, 40 Alderney Drive, 4th Floor, Dartmouth, NS B2Y 2N5

February 10, 2004

Mr. Michel Samson, MLA
Chairman, Standing Committee on Veterans Affairs
Legislative Committee Offices
3rd Floor, Dennis Building
1740 Granville Street
P.O. Box 2630, Station M
Halifax, NS B3J 3N5

Dear Mr. Samson:

First of all let me thank you again for inviting our department, Veterans Affairs Canada (VAC), to make a presentation to your Committee. Veterans are very fortunate that the Province of Nova Scotia takes pride in assisting them through such a forum.

Committee members had some questions to which we were unable to offer a full reply at the meeting, so I am writing to provide further explanation and clarification on those particular items:

- **Veterans Independence Program (VIP) Lifetime Continuation for Spouses**

  In November 2003, Minister Pagtakhan announced the continuation of VIP for widowed spouses of Veterans.

  To qualify, survivors and other primary care-givers must be assessed as requiring the housekeeping and/or grounds maintenance services due to health needs and to remain independent at home. The Veteran must have been provided with these services any time after September 1, 1990, and have been receiving them at the time of death. Primary care-givers must also demonstrate that, at the time of the Veteran's death, they maintained or were maintained by the Veteran, they were residing with the Veteran, and they were the adult primary care-giver of the Veteran and were not receiving wages for providing that care. Payments will not be retroactive.

  Survivors and other primary care-givers of a Veteran who died after September 1st, 1990 and within one year of being admitted to a long term care facility may also be eligible and will be required to undergo a similar assessment.

  VAC is planning an information campaign to reach eligible survivors and ensure that those who qualify start getting support as quickly as possible. VAC will start contacting by mail

.../2

Canada

those survivors who formerly received these services to determine if they qualify. Survivors who think they may be eligible and other primary care-givers who may qualify are asked to call 1-800-443-0382 (toll-free) for information on how to apply for housekeeping and/or grounds maintenance services.

❑ **Last Post Fund (LPF) and unmarked Veterans' graves**

Through a Memorandum of Understanding between Veterans Affairs Canada and the Last Post Fund, administration and provision of Funeral and Burial Grants and departmental Service Markers has been handed over to The Last Post Fund, a non-profit organization. Provision of these "benefits" is accomplished in one of three ways:

- Departmental service markers are provided as a *matter of right* for eligible pensioners whose death was attributible to their pensioned condition. These *matter-of-right* markers are fully funded by VAC and there are usually no delays in placement.

- When a Funeral and Burial Grant (means-tested financial assistance for costs) is approved for a Veteran who does not qualify under the *matter of right* provision, a departmental service marker is automatically provided. For those Veterans who qualify for Funeral and Burial Assistance, VAC fully funds the grave marker and, again, there are usually no delays in placement.

- When the family of a deceased Veteran has paid for the funeral and burial, eligibility for markers is means tested, and lengthy delays in marking graves can occur. In these cases, grave markers are provided by LPF, within available funding, beginning with those applications which have remained outstanding for the longest period of time. In its mission statement, the Last Post Fund states that one of its purposes is *"to provide grave headstones for war veteran graves that have been unmarked for more than five years."* Prior to the agreement between VAC and LPF, these markers were solely the responsibility of LPF, without VAC funding.

  The current situation, stipulated in the agreement with VAC, is that the Corporation is required to provide VAC with annual estimates and budgets for program expenditures. The Department funds this last aspect of the program based on these estimates. Funding for provision of grave markers for unmarked graves in Nova Scotia for 2004 from VAC is approximately $5,000, an increase of $1,500 from 2003.

  A waiting list of unmarked graves in Nova Scotia currently has approximately forty names of Veterans who have died more than five years ago and whose graves are not yet marked. The increased funding should reduce the number of names on the waiting list for grave markers by ten to twelve.

.../3

❑ **Canada Remembers Youth-Related Programs**

Please refer to Attachment 1 for a comprehensive listing of our programs and products aimed at reaching Nova Scotia youth.

❑ **Merchant Navy Applications**

In reference to the ex gratia Merchant Navy Veteran Special Benefit initially approved in February 2001, VAC received 14,000 applications nationally, of which 8,300 were approved. Of those national totals, there were 2,796 applications from Nova Scotia, of which 1,441 were approved.

In terms of regular benefits, in 2003 we received eight applications coded as Merchant Navy or Civilian Merchant Seaman. Only one of those applications was approved.

It should be noted, however, that throughout the course of the negotiations for the ex gratia Merchant Navy Special Benefit package, there was tremendous promotion of the regular benefits available to Merchant Navy Veterans through VAC. As a result, many of Nova Scotia's qualified Merchant Navy Veterans are already in receipt of benefits - War Veterans Allowance, Treatment Benefits, Disability Pensions.

You may also be interested to know that lack of proof of Merchant Navy service is not necessarily the most common reason for denial of benefits - particularly as statutory declarations are admissible as proof. Some other fairly common unmet criteria include:

- Veteran also served in the Canadian Forces for more than one year (criteria for special benefit package);
- Veteran was not domiciled in Canada or Newfoundland at the time of their service; or
- there was no qualifying voyage - simply being on the water during the war does not necessarily qualify an individual as a Merchant Navy Veteran.

❑ **Veterans Affairs Field Staff**

Please refer to Attachment 2 for a listing of Veterans Affairs Area Counsellors and their respective areas of responsibility.

❑ **Gym Memberships for Veteran Clients**

This issue was addressed in a separate letter dated January 30, 2004.

.../4

- **Assistance with roof repairs at the Military Museum in Cornwallis, Nova Scotia**

  Regrettably, at this time, VAC does not have the mandate or the funds to make financial contributions to the maintenance or repair of memorials or museums. Our A/Associate Director General, Barry Gallant, has spoken to MLA Harold Theriault's office staff and with Mr. Jerry Cann from the community, advising them to contact our office early in April (the commencment of our new fiscal year) to discuss possible areas or means by which we could aid the project to completion. It was also suggested to Mr. Cann that he contact Department of National Defence Public Relations Office to determine if they could be of assistance.

- **Provision of two Priority Access (Long-Term Care) Beds for Tatamagouche Hospital as approved by former VAC Minister, George Baker**

  Former Minister of Veterans Affairs, George Baker agreed to the possibility of contracting with the Province of Nova Scotia to provide two Priority Access Beds for the Tatamagouche Hospital, given there was a need and that the Province agreed. In two subsequent ministerial responses, both he and the Former Minister Rey Pagtakhan have replied that new programs put in place by VAC are meeting the Long Term Care needs of Nova Scotia Veterans.

  In February 2002 Mr. Pagtakhan met with the Honourable Bill Casey and committed to having the Department review the situation in Tatamagouche. In the spring of 2002, Mr. Casey was advised that there were no Veterans from the area whose health care needs were not being met.

  As of July 2003, there were four Veterans receiving care at the Willow Lodge at VAC expense under the Veterans Independence Program.

  The department has a fiscal number of beds; and in order to place more beds into a community, they must be moved from other locations. Given the current demand in the Tatamagouche area, the department has been able to meet Veterans' needs through community facilities. We continue to monitor this situation and if it changes, we will again consider the relocation of beds to Tatamagouche.

I trust this information will assist your members in understanding our programs and providing advice to their constituents. If you require any further clarification, or if we can be of assistance in any way, please do not hesitate to contact our office at (902) 426-4496.

Sincerely,

Krista Locke

Krista Locke
A/Director General, Atlantic Region

Encl. 2

Attachment 1

Veterans Affairs Canada, Atlantic Region
Canada Remembers Youth-Related Programs

Canada Remembers Learning Resources

To assist educators in teaching Canada's military history, Veterans Affairs Canada has created a variety of exciting resource materials (teaching kits/modules) that are available, free of charge, in both official languages. These products can be ordered from our web site at www.vac-acc.gc.ca, or by phoning toll-free 1-877-604-8469.

- **Canada and the Great War 1914-1918 (Grades 7-12):** Focuses on how the First World War impacted Canadians and our lives today by following the story of Canada's rise from colony to nation.

- **Canada's Coming of Age 1939-1945 (Grades 7-12):** CD-ROM which offers a wealth of information including film and radio clips, photographs, newspapers, letters, diaries, and more, bringing the war years to life, with a sense of understanding and pride in the accomplishments of Canadians.

- **Sacrifice, Achievement, Legacy - Canadians and the Second World War 1939-1945 (Grades 7-12):** Canada earned an international reputation for its part in the Second World War, entering the post-war world with a new confidence. This kit will challenge youth to discover more about Canada's role and the thousands of brave young Canadians who served.

- **Canada Remembers the Korean War 1950-1953 (Grades 7-12):** To mark the 50th Anniversary of the Korean War Armistice, this learning kit was designed to bring alive Canada's contribution to one of the initial major military actions of the United Nations.

- **In the Cause of Peace and Freedom: Tomb of the Unknown Soldier (Grades 9-12):** In May 2000, the Tomb of the Unknown Soldier was unveiled in Ottawa, representing and honouring all Canadians who have suffered and died in the cause of peace and freedom. This module will help young people become aware of the causes and consequences of war.

Veterans' Week (November 5-11) resources

Each year, Veterans Affairs produces a variety of classroom resources, reflective of the theme for that year. These materials can be ordered, free of charge, on-line at www.vac-acc.gc.ca starting in early September, or through a direct-mail order form sent to each individual school in August.

- **Veterans Week Poster:** Produced annually since 1981, each year's poster focuses on a theme or relevant commemorative anniversary.

- **Bookmarks**

- **Take Time to Remember Activity/Colouring Books (Primary to Grade 3):** Class set of colouring books with educational activities features people and places that played important roles in Canada's wartime history.

(over)

- **Road to Peace Activity Sheets (Grades 4 to 6):** Class set of colourful activity sheets with information and hands-on puzzles and trivia to help young people understand the importance of remembrance.

- **Postcards for Peace (Grades 6 to 12):** Class sets of remembrance postcards that students can send to Canadian Peacekeepers around the world, or to Canadian Veterans to thank them for their contribution to world peace. Mailing addresses for peacekeeping operations and Veterans Affairs contract long-term care facilities provided in accompanying Teachers Guide.

- **Courageous Canadians Quiz (Grades 9 to 12):** A sheet of questions and photos centred on Canada's involvement in the First World War which may shape and animate class discussion or test students' knowledge of Canada's wartime experience. The quiz is also available on the VAC Web Site.

Veterans Affairs Canada Web Site (www.vac-acc.gc.ca)

The Veterans Affairs Web Site contains an extensive collection of information on Canada's military history, including all VAC publications and the digitized version of the *Books of Remembrance*.

- **Korean War WebQuest:** An interactive tool to learn individually as well as collaboratively. WebQuest is designed as an assignment in which learners take the role of publishers and work together to prepare a classroom coffee table book about the Korean War.

- **Prose and Poetry:** Students are to submit essays, letters, poetry, and thoughts on remembrance. Submissions will be posted on the VAC web site.

Veterans' Week Youth Ambassador Program (Atlantic Region)

This program encourages youth to plan and get involved in Veterans' Week activities in their community by talking to their peers, community organizations, or writing or speaking to their local press. Potential Youth Ambassadors are identified through recruitment letters (or email) to groups in the Atlantic Region (such as cadets, RCL branches). In particular, students who have participated in VAC-sponsored events (pilgrimages, learning tours, etc.) are called upon to present their experiences in different venues. A Speakers' Kit is sent to each identified Youth Ambassador to equip them to promote Veterans' Week and Remembrance in their group, school or community.

Student Guide Program in France

The Student Guide Program in France, managed by Veterans Affairs Canada through the Federal Student Work Experience Program (FSWEP), is the opportunity of a lifetime to travel, meet long-lasting friends, and teach people from around the world about Canadian history in both official languages. Students from across Canada live and work in France for four month periods as interpretive guides at memorial sites including the Canadian National Vimy Memorial, and the Newfoundland Beaumont-Hamel Memorial. Further information is available on our web site at www.vac-acc.gc.ca.

Attachment 2

VAC NOVA SCOTIA AREA COUNSELLORS: DIVISION OF GEOGRAPHIC AREAS

AC83 Glenn Craine	
B0J 1N0	Head of Chezzetcook
1P0	Head of Jeddore
1W0	East Jeddore
1Y0	Lake Charlotte
2J0	Mooseland
2L0	Musquodoboit Harbour
2R0	Port Dufferin
3A0	Shearwater
3B0	Sheet Harbour
3H0	Spry Bay-Mushaboom
B2V (all)	Dartmouth-Cole Hbr
B2W (all)	Dartmouth Stn East
B2Z (all)	Lawrencetown
B3E (all)	Porters Lake
B3G (all)	Eastern Passage

AC84 Carolyn Fuller	
B0N 1G0	Cheverie
1H0	Curry's Corner
1J0	Densmore Mills
1L0	Ellershouse
1P0	Kennetcook
1T0	Maitland
1Z0	Mount Uniacke
2A0	Newport Corner
2B0	Newport Station
2C0	Noel
2E0	Ste Croix
2G0	Scots Village
2K0	Summerville
2L0	Upper Kennetcook
2N0	Upper Rawdon
2R0	Walton
2T0	Windsor
B0P 1B0	Avonport
1L0	Falmouth
1M0	Grand Pre
1P0	Hantsport
B4E (all)	Middle/Lower Sackville
B4G (all)	Beaverbank
B4P (all)	Wolfville

AC85 Darlene MacAulay	
B0W 1B0	Arcadia
1L0	Carleton
1X0	Hebron
1Y0	Kemptville
1W0	Glenwood
B0W 2B0	Lower Wedgeport
2H0	Mavilette
2J0	Meteghan
2K0	Meteghan Centre
2L0	Meteghan River
2V0	Port Maitland
2X0	St. Anne du Ruisseau
2Y0	Salmon River
B0W 3E0	South Ohio
3M0	Tusket
3P0	Wedgeport
B5A (all)	Yarmouth

AC86 Lee Hartinger	
B0K 1E0	Malagash
1H0	Pictou
1K0	Port Howe
1L0	Pugwash
1M0	Pugwash Junction
1N0	River John
1P0	Salt Springs
1R0	Scotsburn
1V0	Tatamagouche
1Y0	Wallace
B0M 1C0	Belmont
1G0	Debert
1M0	Londonderry
1Z0	Wentworth
B0N 1K0	Elderbank
1V0	Meaghers Grant
1X0	Middle Musquodoboit
1Y0	Milford Station
2H0	Shubenacadie
2J0	Stewiacke
2M0	Upper Musquodoboit
B2S (all)	Elmsdale/Lantz/Dutch S.
B2T 1**	Enfield/Fall River

VAC NOVA SCOTIA AREA COUNSELLORS: DIVISION OF GEOGRAPHIC AREAS

AC88 Carol Moore	
B3H (all)	Halifax Peninsula except Camp Hill VMB
B3J (all)	Halifax Peninsula
B3K 1**	Halifax
B3K 2**	Halifax
B3L (all)	Halifax Peninsula
B3N (all)	Halifax Northwest Arm
B3S (all)	Halifax Northwest Arm

AC89 Grace Girard	
B0J 1B0	Black Point
1E0	Blockhouse
1J0	Chester
1K0	Chester Basin
2C0	RR 1,2,3 Lunenburg
2E0	Mahone Bay
2W0	Riverport
2X0	Rose Bay
2M0	New Ross
3M0	Western Shore
B0R 1A0	RR 1,2 Barass
1E0	New Germany
B4V 1**	Bridgewater
2**	Bridgewater
3**	Bridgewater
4**	Bridgewater

AC90 Ray Simmons			
B0J 1H0	Brooklyn	B0W 2T0	Port Latour
1V0	Italy Cross	2W0	Pubnico
2H0	Mill Village	3B0	Shag Harbour
2P0	Petite Riviere	3K0	Cape Sable Island
2T0	Port Medway	3N0	Upper Port Latour
B0R 1C0	LaHave	3S0	West Pubnico
1G0	Pleasantville		
1H0	Springfield		
B0T (all)	Liverpool/Shelburne		
B0W 1C0	Baccaro		
1E0	Barrington		
1G0	Barrington Passage		
1K0	Cape Negro		
1N0	Clam Point		
1P0	Clarke's Harbour		
1R0	Clyde River		
1T0	East Baccaro		
B0W 2A0	Lower East Pubnico		
2C0	Lower West Pubnico		
2E0	Lower Woods Harbour		
2G0	McGrays Cove		
2M0	Middle West Pubnico		
2P0	North East Point		
2S0	Port Clyde		

VAC NOVA SCOTIA AREA COUNSELLORS: DIVISION OF GEOGRAPHIC AREAS

AC95 Pam Schleihauf	
B0L 1A0	Joggins
1B0	Maccan
1C0	Nappan
1E0	Northport
1G0	River Hebert
B0M 1A0	Advocate Harbour
1H0	Bass River
1E0	Collingwood
1J0	Economy
1K0	Five Islands
1L0	Great Village
1H0	Diligent River
1N0	Lower Five Islands
1P0	Oxford
1R0	Oxford Junction
1S0	Parrsboro
1T0	Port Greville
1V0	River Philip
1W0	Southampton
1X*	Springhill
B4H (all)	Amherst

AC96 Carolyn Brown	
B0K 1B0	Eureka
1C0	Hopewell
1S0	Stellarton
1W0	Thorburn
1X*	Trenton
2A0	Westville
B0N 1C0	Brookfield
2P0	Upper Stewiacke
B2H (all)	New Glasgow

AC98 Marian Stauch-Kennedy	
	Camp Hill VMB
B2X (all)	Dartmouth
B2Y (all)	Dartmouth
B3A (all)	Dartmouth
B3B (all)	Dartmouth
B3K 3**	Halifax
4**	Halifax
5**	Halifax
B2R 1**	Waverley

SYDNEY DISTRICT OFFICE
Jennifer McNenly
Port Hawkesbury
Cheticamp
Richmond County
Louisbourg
Baddeck
Victoria County
Antigonish
Lori Murray
Guysborough
Port Hood
Mabou
Inverness
Margaree's
Sydney Mines/Bras d'Or
Beverly MacDonald
New Waterford
Dominion
North Sydney
Jeanne Wilcox
Sydney

VAC NOVA SCOTIA AREA COUNSELLORS: DIVISION OF GEOGRAPHIC AREAS

AC91 Doug Lee	
B0P 1N0	Greenwood
B0P 1W0	Wilmont
B0S (all)	Annapolis Royal/ Bear River
B0V (all)	Digby/Freeport/Tiverton
B0W 1H0	Barton
1J0	Belliveau Cove
1M0	Church Point
1Z0	Little Brook
2R0	Plympton
B0W 2Z0	Saulnierville
B0W 3T0	RR 1,2,3,4 Weymouth

AC92 Ken Duncan	
B0P 1A0	Auburn
1C0	Aylesford
1E0	Berwick
1G0	Cambridge
1H0	Canning
1J0	Centreville
1R0	Kingston
1T0	Port Williams
1V0	Wateville
B4R (all)	Coldbrook
B4N 1**	Kentville
2**	Kentville
3**	New Minas
4**	New Minas
5**	New Minas

AC93 Lisa Ellsworth	
B0J 1G0	Boutiliers Point
1T0	Hubbards
3J0	Tantallon
3L0	West Dover
B3M (all)	Bedford Highway
B3P (all)	Halifax
B3R (all)	Halifax
B3T (all)	Timberlea-Lakeside
B3V (all)	Williamswood
B3Z 1**	Hubley/Hammonds Pl.
2**	Head St. Margarets Bay
3**	Glen Margaret/Hacket C.
4**	Ingramport
B4A (all)	Bedford
B4B (all)	Hammonds Plains

AC94 Mary Burey	
B2N 1**	Truro
2**	Truro
3**	Truro
4**	Truro
5**	Truro
6**	Truro
7**	Truro
B4C (all)	Lower Sackville

APPENDIX C

Legislative Committees Office
House of Assembly
Nova Scotia

3rd Floor, Dennis Building
1740 Granville Street
PO Box 2630, Station M
Halifax, Nova Scotia
B3J 3N5

March 4, 2004

Hon. Ron Russell
Minister
Department of Transportation
& Public Works
PO Box 186
Halifax, Nova Scotia
B3J 2N2

Dear Mr. Russell:

Thank you for your correspondence of February 4, 2004 and the documentation regarding the provincial rest stops in Cumberland County and Pictou County.

Upon discussion of the provided material, the Standing Committee on Veterans Affairs unanimously passed the following motion:

> "Therefore be it resolved that the Standing Committees on Veterans Affairs call upon the Minister of Transportation and Public Works to seek an amendment to the existing Memorandum of Understanding with the two developers for provincial rest stops and to add in a clause which would require where fuel service is made available at the provincial rest stops that a minimum requirement be established for providing full service fuel service to address the issues raised by the seniors, Legions, veterans and other concerned Nova Scotians."

Also,

> "That it also be resolved that the Department of Transportation and Public Works of the Government of Nova Scotia make it a mandatory requirement that any future provincial rest stops, in their Memorandum of Agreements if fuel service is to be provided, that minimum requirements are established for full service fuel service."

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Hon. Ron Russell

Enclosed is a copy of the Hansard transcript of the meeting for your perusal.

The Standing Committee on Veterans Affairs looks forward to hearing from you.

Sincerely,

Mr. Michel Samson, MLA
Chairman
Standing Committee on Veterans Affairs

Encl.: 1

MS/dh

Transportation
and Public Works
Nova Scotia Office of the Minister

PO Box 186
Halifax, Nova Scotia
Canada B3J 2N2

Our File Number

March 23, 2004

Mr. Michel Samson, MLA
Chairman
Standing Committee on Veterans Affairs
PO Box 2630, Station M
Halifax, NS
B3J 3N5

Dear Mr. Samson, Michel

RE: Highway Rest Areas, Cumberland County and Pictou County

I am writing in response to your letter of March 4, 2004, informing me of two resolutions passed by the Standing Committee on Veterans Affairs.

The first resolution sought amendments to the existing agreements with the proponents currently involved in the development of rest areas in Thomson Station in Cumberland County and Cowan Street in the Town of Westville. I regret to inform you the Department of Transportation and Public Works will not renegotiate these agreements. These developments proceeded on the basis of business decisions that resulted from the proponents' review of the rest area core criteria. It would not be appropriate for the Department to place additional conditions upon the proponents after they have proceeded with their development.

The second resolution forwarded by the Standing Committee sought the Department make it a mandatory requirement that any future rest area development where fuel service is provided, the proponent must provide full service fuel service. The Department will consider including such a requirement at future rest area developments.

I recognize the Standing Committee is attempting to influence the services provided across the retail fuel market; however, I would like to state that fuel services are not a mandatory requirement at highway safety rest areas.

The Standing Committee may have greater success in influencing fuel retailers by forwarding their concerns to the "Retail Gas Dealers Association". Mr. Graham Conrad, Executive Director for this association, may provide a better source to deal with the veterans' concerns. Mr. Conrad may be reached at:

Retail Gasoline Dealers Association of Nova Scotia
4327 Prince Albert Road, Suite 4
Dartmouth, NS
B2Y 1N7

Phone: 466-7516

Printed on paper that

Thank you for your interest in rest area development on provincial highways.

With personal regards,

Honourable Ronald S. Russell, CD
Minister

/kl

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http://www.gov.ns.ca/legislature/hansard//comm/va/